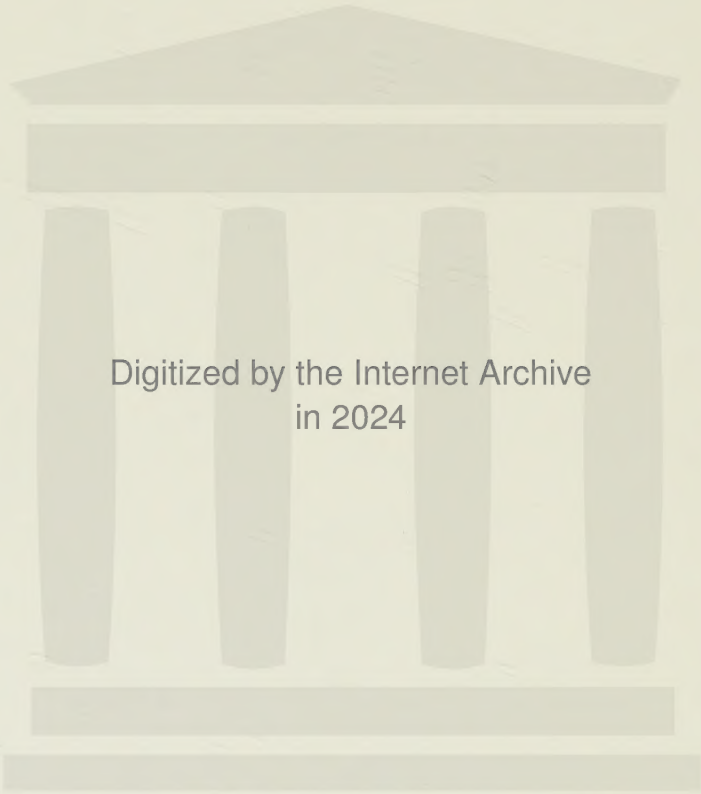
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HOW PSYCHIATRISTS LOOK AT AGING
VOLUME 2

Mental Health Library Series

Monograph 3

edited by
George H. Pollock, M.D., Ph.D.

HOW PSYCHIATRISTS LOOK AT AGING
VOLUME 2

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George H. Pollock, M.D., Ph.D.

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WITHDRAWN

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Introduction

George H. Pollock, M.D., Ph.D.

Life is a one way street and there are no U-turns. The awareness that there is a developmental process associated with aging is a concept some are reluctant to acknowledge. Aging is development and change. Recognizing the realities of these changes can be stressful to some. Others may deny the impact of this process. Still others will attempt to cope with these realities, physical and emotional, in various ways that are minimally uncomfortable. However, growth itself can be painful when it involves meaningful alterations of prior feelings, beliefs, and behavior. Acceptance of a new or changed reality may involve loss and compromise. We in the mental health professions are as prone to the reactions to our own aging as are others. However, by examining ourselves we may be in a position to share insights with others who may be less exposed to aging processes and their vicissitudes.

With this in mind, I invited older colleagues to share with our readers some of what they have learned about their own aging and the various changes that are apparent at different periods of the life course. Our first volume of this series has already been published. It was received quite favorably by our professions and the lay public. This present collection is the second of the series. We hope it will yield additional insights and be of assistance to those involved with their own aging confrontations and to younger colleagues who increasingly will be working with older adult patients. We hope to continue with the series and are currently working on our third volume. We are also preparing an anthology edited by Dr. F.M. Baker and me,

on personal experience dealing with retirement and nonelective unemployment. Increasingly we see individuals affected by these alterations in the work area. My own research on a taxonomy of "work pathology" also points to the significance of these issues and stresses. This is an area upon which mental health professionals should focus.

I thank the many colleagues who have shared their feelings and experiences of aging in the chapters they prepared for these volumes. Their willingness to teach us about their own aging hopefully benefits us and the contributors themselves. A retrospective view of one's life can make the road ahead an easier one. As one of my patients told me, "when I come to a fork in the road, I pick up the fork and move on." We know where the road ends, but we do not know when we will reach that point in time, place or circumstance. Until then, "pick up the fork," and continue what hopefully is a pleasant journey.

1

On Aging

Louis A. Gottschalk, M.D., Ph.D.

A psychiatrist's and psychoanalyst's special perspective on aging should involve the relationship of aging to the functions of the brain and mind. This perspective is likely to engage more than the psychology and physiology of the aging process, but also includes the effects on oneself of the aging and passing of others, as well as the witnessing of one's own aging and prospective dying.

This author has reflected on how to address the topic and has been tempted to review it in an orderly and systematic way, much as a medical text organizes the subject and covers thoroughly and in a systematic manner every detail listed in the table of contents. I will resist this, however, and instead touch here and there in a series of short discussions, calling upon my skills in self-analysis and self-scrutiny, on personal insights and self-observations. In this way I hope more informally to share some of my psychiatric and psychoanalytic expertise in the matter of aging. I do not know how I can avoid, thereby, becoming engaged in occasional autobiography.

THE LIMITS OF MY QUALIFICATIONS TO PONDER AGING

Everyone experiences aging, from infancy through senescence, through each developmental stage of life. What can I perhaps contribute to the subject that everyone does not already know? As a psychiatrist and psychoanalyst, I am a schooled observer and listener, and I

customarily employ self-scrutiny and self-reflection to sharpen my perception of others by distinguishing my self from others.

I notice that patients and personal acquaintances tend to avoid discussing their aging unless they suffer from a malady or their prowess, especially their physical prowess, has been compromised by the passage of time. Some people discuss ending their life willfully and explain, on request, why they are considering such an action. In doing so, unless they were professional athletes, they do not usually report at length their dismay over aging. I think there is considerable denial or specialized avoidance of this topic by others. I doubt that I, myself, would be writing on the topic if I had not been invited to do so. I would have avoided the subject. But I was attracted to work on the project by the creative challenge.

My father, who died at 86, and my mother, who died at 74, never spoke to me about their aging; neither have my two older brothers, who are still alive. My younger brother recently told me that our father volunteered, laconically, some advice to him regarding aging on one occasion only. He told my brother, "Don't grow old." My father was ordinarily quite a talker and a writer, too, and so is my oldest brother (age 82), and he does not bring up the topic. Like my father, he lives life to the fullest, keeping busy every moment of wakefulness. The next older brother never talks about the process of aging either.

The behavior of these family members reminds me of some anecdotes about George Bernard Shaw when he was in his nineties. He was "a phenomenal worker, every day of his life, with a brain never still or at peace, writing was a necessity to him, as much as bread to another. He wrote fragments of plays until his death at ninety-four . . ." (Williamson, 1963, p. 207). He is reported to have said, "If I stop writing, I must die for want of something to do" (Patch, 1951, p. 296). When he was asked what he thought about the process of aging at 93 he said that he kept so busy he never thought about it.

I recognize that I am made of the same stuff as these people. I notice that everyone else is aging, and I am staying the same. I catch myself wondering, undoubtedly like every older gentleman, why police officers and some television newscasters look so young. Inside my skin, my perceptions and thinking and feeling are typical of myself in the early twenties of my life, even though I am 77. My energy level and my cognitive function seem to be indistinguishable from what I recall of my self at that period of my life. My denial borders on the psychopathological. Reality confronts me when I stand at the

bathroom mirror and shave, or brush what is left of my beautiful curly dark brown hair. I definitely do not like the image I see there. There is a bit of compensation for these strange personal metamorphoses in the fact that my weight still varies between 174 and 176 pounds and has not changed in fifty-three years when I first reached that weight. I still play racketball for exercise. I have to pay attention to occasional backaches and a very slightly anesthetic left hand that my neurosurgeon friend tells me is due to "cervical radiculopathy." Otherwise, my physical health is excellent. The way this body of mine is working conspires to contribute to my illusion of permanence and promotes my thinking of other matters than aging. Yet I am mindful, continually, of the transient nature of my existence. I am of agnostic persuasion and unable to believe I have any special insight or knowledge about ultimate matters or God, though reared in a family of Protestant and Catholic heritage. I am fully aware of my temporariness on this planet and the unlikelihood of some kind of continuity with my progenitors, extended family, immediate family, and offspring in any form that writes, thinks, and feels like me. I mention my existential background and my current existential views, for I have observed that the aging process in others and the way others talk about the process is definitely influenced by their belief systems. I know that many people do not dwell on their aging because they sincerely believe that they are top candidates for immortality; so they, instead, talk about their religious beliefs and their faith in the benevolence of a deity or deities to choose them for eternal life. The denial of others and myself with respect to the process of aging clearly has different bases.

I do not believe my observations on growing old are shared by most people. Good physical health and heredity, a predominantly favorable quality of life, intermingled with rather widely distributed sad events, a gratifying profession and occupation, and other factors discussed later have contributed to how I experience and view the process of aging. I will try to summarize these as I proceed with each of the following discussions.

AT WHAT POINT DOES THE AGING BRAIN FAIL TO RECOGNIZE SERIOUS IMPAIRMENT OF ITS COGNITIVE FUNCTION?

I wonder when the aging brain fails to recognize that it is failing. I have observed some people with Alzheimer's disease, who were typically anxious and depressed during their lifetime, becoming smiling

and cheerful during the later phases of this progressive cerebral degenerative disease. I recall that past period when a crude form of psychiatric treatment called electroconvulsive or electroshock therapy could be observed to dispel the awareness of some depressed or schizophrenic patients of what was disturbing to them about their lives, and along with the temporary memory loss brought on by their electroshock treatment, their depressive or schizophrenic syndrome disappeared, at least for a while. There is clearly a relationship between a failing memory and a change of mood in these different mental disorders. But what is that point in the more gradual course of normal aging where the brain, in examining itself and in weighing the quality of the existence of the body it inhabits, no longer cares so much about what happened or will happen?

If we cannot precisely answer this question, which was in part rhetorical anyway, cannot we ask what part or parts of the brain make up our awareness of where we have been and where we are now, who we are, who we were, and who we shall be? While we are asking such questions, could we also find out what brain connections influence our feelings and attitudes about our identity and past and present history, and why we need to look to the future with a negative or positive appraisal? From appearances, one could safely assume that some structures of the brain carry out these kinds of functions and that these structures, somehow, gradually wear out in normal aging. Or with sudden brain trauma, the capacity for and the interest in self-evaluation may stop. With various brain disorders, such as cancer or Autoimmune Deficiency Syndrome (AIDS), this focus and ability becomes progressively weaker. But the neurosciences have not yet given us the answers to these questions.

Can self-psychoanalysis cast some light on this important matter? Searching first among the self-scrutiny of others, I remember one psychoanalyst friend who developed Parkinsonism. He shared with me the curious experience he was having when driving his car. He would want to accelerate or stop, he would make the decision, and then he would notice that there was an appreciable interval when nothing would happen. Then, after a brief delay, his foot would carry out the voluntary message he sent it. He noted no slowing down of his affective reactions, he reflected, for he was worried about these delays in the responsiveness of his neuromuscular system to his consciously willed desires for one muscular action or another. Soon after telling me about these experiences, he stopped driving his car and

asked his spouse to substitute for him. Nevertheless, in our conversations his voice became softer and softer, so that it became very difficult to hear him; yet I noted that when I would frequently ask him to repeat what he had just said, he seemed to be unaware that he was not communicating well.

In Parkinsonism we know there is a malfunction in the brain's extrapyramidal system and that there is a progressive shortage of the neurotransmitter L-dopa in key cells in the substantia nigra. But how does this help us answer the questions we have raised? My friend was distressed enough with his command of the movement of his body that he had his wife take over his car driving. Did his inability to judge that he was speaking so softly that I could not hear him signify that he was losing the ability to judge the quality of his verbal interpersonal communications? Or was he desperately continuing to talk as well as he could, even though it was not loud enough to hear, because he badly wanted to keep a connection with me? We will never know.

The dopamine neurotransmitter and receptors have other important functions besides influencing neuromuscular functions; they have been implicated in some forms of the schizophrenic syndrome (in terms of an excess of dopamine being available at the synapse, which the phenothiazines can suppress). We should keep an eye on this class of neurotransmitter as being in some way involved in the psychobiological function of consciousness.

Can my own self-observation provide any clues toward solving the problem of the neurobiological basis of consciousness and our capacity to focus on our own mental machinery and tell whether it is working well or beginning to fail? I am frankly not sure. I am tempted to say that though I am nearing the time when the acuteness of my brain functions should start going down hill, since these functions are currently going as well as ever I should have an opportunity using introspection to discover some answers for myself. I have no idea whether I can get any new insights on the matter. I rather doubt that I will be able to do any better than the countless people who have preceded me on this route, but I will try.

As a psychoanalyst as well as a psychiatrist and neurologist, it is appropriate for me to make a final comment here. Psychoanalysts are trained to observe and examine carefully their own mental processes in order to discover their countertransference insights or distortions so that they may perceive more accurately the messages of their analysands. This approach teaches us some healthy skepticism which needs

to be applied to oneself when the psychoanalyst is both analysand and psychotherapist as I sometimes have to be here (Gottschalk, 1989). This will help explain an occasional tone of apologizing for personal limitations and hesitating to generalize to what extent my personal experiences with aging apply to others.

WITH WHAT SUBJECTS DOES THE AGING MIND OCCUPY ITSELF?

I have read some authors (Dunham, 1956; Jones and Kaplan, 1956; Post, 1982) who claim that the aging mind preoccupies itself more and more with the past rather than the present or the future. At first I accepted this statement on the grounds that as one grows older more and more of one's existence has occurred in the past in proportion to one's life expectancy; or one remembers the past better than the present. Now I question these assumptions when I consider that most of the great religions of the world deal with various beliefs involving a future or afterlife, and these religions involve the devotee in ritualistic activities pertaining to the eventual fulfillment of these beliefs.

I did obtain some empirical data many years ago (Gottschalk and Gleser, 1969) that have some bearing on what older people think about. My research collaborators and I collected five-minute speech samples from hundreds of subjects of both sexes which we elicited with purposely ambiguous instructions (to approximate free association) by asking the subjects to talk about any interesting or dramatic life experiences they have had. The typescripts of these speech samples were scored blindly on the Gottschalk-Gleser Anxiety scale which includes six anxiety subscales—death, mutilation, separation, guilt, shame, and diffuse anxiety. The only significant correlation with age was the death anxiety score—the older one gets the more a person talks about topics involving one's death or the death of others or the denial of any preoccupation with death. I am not personally aware that my everyday conversation fits such a finding.

Let us consider with what topics my aging mind occupies itself, a subject that readers may certainly be inclined to view as highly individualized or peculiar to a small group of people, for example, those whose vocation or avocation leads them to use introspection frequently. These self-reflections may have heuristic value and lead readers to make comparisons. As I age I find myself reflecting on

people, especially kinfolk, that I knew in the past and are no longer with us. For example, I think about my mother and the pride she appeared to take in the activities and achievements of each one of her four sons. When father was not home—he was a strict disciplinarian—we boys let loose. We were three years apart, and the levels of sibling rivalry, the arguments, and the occasional wrestling elevated when father was away. As we got older, I can remember our very gently challenging the wisdom of mother's authority. I recall one time she spanked me on the rear end with the heel of one of her shoes, but she spanked so softly that I laughed at her spanking with relief, not recognizing her tenderness at that time. What was she thinking as she coped with the variety of tests we put her to? She never complained that child rearing was a chore.

These memories form a small part of the foundation of my personal optimism and strong ego strength which, in turn, influence how I am facing aging. Another memory of my mother comes to me and, I am sure, contributes with the host of other positive memories of her to my secular optimism and generally cheerful disposition. She left the four of us in a hotel room for a few minutes in Paris, France, to check on our passports! We played a game of hide-and-seek while she was out of the room, and two of us climbed up the partly open drawers of what seemed like a huge chiffonnier so that we could hide in the closed drawers. But before we could close one, the whole chiffonnier fell forward and smashed a very large mirror on it to countless pieces. I remember her coming into the room while we were all trying to right the chiffonnier and pick up or hide pieces of the glass mirror. She took us all downstairs and reported the accident to the hotel management. They told her, all in French in adult terms we could only partly understand, what it was going to cost her. She wrote her name on what must have been some travelers' checks and paid for the damage on the spot. She simply told us we should not have done this thing, and we did not hear any more about it. Now I wonder whether she did not criticize us later simply because we kept getting into so much other mischief, and she did not have time to bring up the past. Were we model children? No, we were ordinary children.

I think now she must have believed the problems she encountered in parenting were part of everyday life and that such events constituted one of the joys, rather than the vicissitudes, of parenthood. One of her wise sayings to us when we were upset about something was to advise us to consider what difference some apparent

catastrophe would make in a hundred years. Surely she must have used such counsel on herself. Moreover, she conveyed a sense of enjoyment and adventure about her role in life. Is that the way she thought and felt privately about her identity? Those are issues that I reflect on nowadays whenever I play back in my mind some memories of scenes of our family life. I believe her good nature brushed off on all of her offspring. These kinds of reflections, that often deal with the quality of mothering we boys received, support my viewpoint that how successfully one copes with aging throughout the life cycle depends heavily on the quality of the mother–child relationship.

I also reflect frequently about my relationship with my father. I can remember during my late adolescence my thinking what an unusual father I had—a gifted man, a nonpracticing attorney, making his livelihood as an artist, musician, composer, and writer. He was a continual raconteur and showman, the unquestioned head of the family! I think I had decided about that time of my puberty that he belonged more in a novel or in a fictional drama, rather than in a real-life story. I still believe he was an unusual character and not the kind of average man who one would, today, think would want to rear a family. But he was definitely a family man: proud, devoted, generous, doing things with us and making things for us. Quite creative, yet strangely competitive with his own offspring. In a brief fit of fury, over what I do not know, he once lined us four boys against the wall and told us he had more talent in his little finger than all of us put together. He had a younger brother who must have challenged his wits, and he was momentarily replaying the role of an older brother with his own offspring. He might, even, have been plagued by a reverse oedipal conflict. He certainly motivated me to try to perform well—not in music or the arts where he certainly had quite a discouraging headstart—but in my chosen profession.

He set a wonderful example for us on how to age gracefully after 70. He confided in me once in a while, as he no doubt did with all his sons, that when I was older I would understand better what he was going through and how it was to be a parent. He was certainly right! The younger generation does not seem regularly to respect the opinions of elders, but what is wrong with that? I often think now of his saying this sort of thing. But am I thinking about adulthood and the changing views we have about our existence during the life cycle in the same way he did? No and yes. These kinds of mental preoccupations are some of the features of my own aging process. Through my

father–son relationship I did learn a great deal about the expected fatherhood role in our society, and I must admit that his vigorous way of sustaining "the slings and arrows of outrageous Fortune" have served me well as a model to emulate.

I am beginning to believe that though both parents clearly set examples, in all phases of development from early middle age and beyond, on how to best perform in each expected role during the progressive stages of life, the parent of the same sex sets a powerful paradigm. Perusing the opening paragraphs of a letter from my father (dated November 19, 1951) I am struck to read:

> I'm seventy-five years old today. Feel like a kid as I sit at my desk writing you this. In reference to the opera, don't think for a minute that I have grown lethargic toward the project. No quite the contrary. I am bearing down on it more than ever quite to the detriment of my painting and practicing (on the violin or piano). For just what reason you will see toward the end of this effusion—which I feel is going to be a long one—if you have the patience to read it through.

In the lengthy letter he intersperses details about his life, stretching onward from his youth, with his long-term ambitions and activities working on and getting criticisms on his grand opera, which he hoped would be the American opera. What is striking to me as I write this discussion on aging forty-one years after receiving this letter from my father is our similarity—both of us in the autumn of our lives feeling young and vigorous and busying ourselves in a creative writing project. Hereditary or environment, or both? He lived to the age of 86, and then succumbed, to a rapidly growing cancer. Until the end, he was continually writing, composing, painting, and discussing music, art, and literature. I am inclined to look forward to and hope for an equally adventurous voyage until the endpoint.

As time passes, however, one does not have to be a physician to become more and more aware of friends, acquaintances, and strangers who have fallen never to rise again, some suddenly and unexpectedly and some from progressively disabling and debilitating illnesses that tax their pride and cause their self-esteem to wane. Denial and denial and denial of the inevitable termination of existence becomes difficult to maintain successfully! On the other hand, dwelling on the experience of a state of nothingness or on how it would be to have no self-consciousness evokes no sense of pleasure. There does occur an evanescent daydream of eventually becoming part of a huge family

reunion, yes, extended to having a city, county, state, national, world, universal reunion. But this wish is quickly followed by such a strong idea of improbability that it is recurringly rejected, not without a touch and, I confess, an occasional heavy dose of transient melancholy mixed with a pinch of resignation. The remedy, if not a cure, for these short-lived sad feelings over the prospect of a permanent interruption of psychosocial continuity is the continual organizing of interesting projects, either creative, recreational, or social. Since I happen to be one of the lucky persons who loves his work, I find it very easy and satisfying to be actively engaged in the creative aspects of this profession. But kinship relationships and activities seem to place first in the priorities of events significantly contributing to the quality of my life. I suspect this feeling is shared by most people and, certainly, by older people. I will amplify on that topic later.

AGING DURING THE SUCCESSIVE STAGES OF THE LIFE CYCLE

At the beginning of the first of this series of little discussions on aging, I commented that everyone experiences aging, from infancy through senescence, during each developmental stage of life. I would like to return to that topic and elaborate on it further, borrowing some ideas from a previous publication that dealt with the normal evolution and development of narcissism and the treatment of its disorders (Gottschalk, 1988).

I suspect most, if not all, of the other contributors to this volume, will not consider that the aging experienced during successive stages of the life cycle has any pertinence to how one deals with senescence. However, let me approach the matter in my own way.

FROM BIRTH TO AGE FIVE

From birth to age 5, the human organism goes through revolutionary changes. Any events which challenge the infant's sense of self-absorption, self-importance, and magical power lead to protests from the child against these challenges and disruptions. Even the unborn fetus becomes progressively more able as it ages to recognize disturbances, whether those involving the vascular supply, the quality of nutrition

through the placenta, the exposure to adverse chemical substances, infection or physical trauma, and so forth. This takes place, although its simple physiological and behavioral adaptations to such disturbances are not readily observable by human adult oganisms. Communication with the infant through the medium of language is not possible; its distress has to be inferred through other channels of communication, such as its inarticulate cries, the vocal qualities of these cries, and its kinesic activities. A growing scientific literature dealing with infant psychology and psychiatry lends support to the hypothesis that the quality of infant–adult interaction at this stage of the life-cycle can contribute to the shaping and molding of the genetically inherited behavioral propensities of the baby. The human child caretakers and the quality of their parenting behaviors continue to influence the neurochemistry and plasticity of the child's developing central nervous system throughout this period of life. I select the age of 5 rather arbitrarily as a possible landmark for this period, for it is often the age when the child first leaves the safety of the home for schooling outside the home, though many children nowadays begin to attend nursery school earlier at 2.5 or 3 years or they are sent away from home for some other form of day care by working parents.

Are these experiences of infancy and early childhood remembered sufficiently to have any telling effect on how the aged adult human being perceives and copes with old age? I think they are. I think these experiences have left indelible biological marks in the brain in the form of proteinaceous traces; the memories of these events cannot easily be recalled at will and, hence, are classified roughly as unconscious memories. Does the fetus exposed to toxic doses of ethyl alcohol or an infectious agent remember the intrauterine experience? No, not in the sense of being able to recall at will the adverse events, but the scars are left in the child's body and these markers influence the subsequent development and learning capacity of the growing child. These persisting earmarks of previous biological insults to the human organism definitely affect how well or badly the child copes with each subsequent developmental stage of life.

More obviously, perhaps, let us consider the prematurely born infant, who comes into the world unprepared biologically to cope with the extrauterine milieu, and who can survive only through advances and innovations provided by medical science. Previously these babies would have died, today they can be with us. Does a prematurely born baby—who has had to have extra oxygen supplied to it—while it exists

and plays for the first two years of its life, think that life is especially precarious? Or does such a child have a greater capacity to trust the altruism of others and fewer illusions than the rest of us do that existence is a garden of Eden? Is such a child better prepared than others who had a full-term birth to cope with becoming old? These are, of course, rhetorical questions, to make us consider the effect of aging during this stage of life on how we regard becoming old. I will ask more such questions later—I do not claim I have the answer to all of them.

I am now treating a very attractive late teenager who was born with a congenital heart disorder such that when she cried or exerted herself in other ways during the first two to three years of her life, she would become cyanotic. The congenital heart disorder corrected itself gradually so that by the time she was 10 years of age it could no longer be identified or detected. But the anoxia on exertion as an infant and young child damaged her brain so that she now has dyslexia and an intelligence quotient of 75 to 80 as an adolescent. Today she suffers low self-esteem and frustration in not being able to achieve the goals she sets for herself educationally and vocationally. Someday she would like to be married. She feels ashamed that she loses her temper easily. She often thinks of suicide. We might say her ego ideal is too high or that she is depressed because she cannot reach her aspirations. Her parents are willing and able to provide her with the best remedies for her mental disorder that science can, today, provide. What will happen during the course of her life? Will she be blessed with the forgetting of her aspirations as she ages? Studies of the mentally retarded indicate that they suffer more from the psychoneuroses and personality disorders than people who are not mentally retarded (Russell, 1989). Can psychiatric treatment help make the path of maturation and senescence easier? The maturational hardships that this girl encountered during her first years of life are adversely influencing her psychosocial development during adolescence. Will not these tribulations further affect her ability to age gracefully?

THE AGES OF 5 THROUGH 10

During the ages of 5 through 10, referred to as the latency period by psychoanalysts, children have to face the unrelenting process at school and in the home environment of going through graded experiences

in which they are expected to acquire knowledge according to progressively more stringent standards of performance. Unconditional love is minimized both at school and at home, and only what the society considers achievements are rewarded. Parental loss by divorce or death, complicated by inadequate substitute parenting, poor or deficient parental and sexual role models, exposure to poverty or environmental disasters (such as wars, earthquakes, hurricanes, disease), sociocultural biases—these and more shape the personality development, self-confidence, and coping ability of the child. Do not such experiences make the child more vulnerable to the problems encountered in old age? It is difficult to generalize accurately about such matters.

THE AGES OF 11 THROUGH 19

During puberty and adolescence most societies require that pubertal and adolescent youth do the following: (1) Show evidence of responding to the customs and standards of a peer group and acquire a capacity to give and to take acceptably from this peer group. (2) Show an understanding and appreciation of the sexual roles and responsibilities dictated by the society of adults. (3) Acquire knowledge and skills that can be used toward the pursuit of a vocation. (4) Achieve some concept of one's identity and the identity one wishes to pursue. (5) Learn how to love others and be loved in socially acceptable ways. (6) Develop an interest in maintaining one's physical and mental health. (7) Evolve a socially workable and self-respecting existential belief system.

Acquiring an appropriate and healthy level of self-love is largely dependent on the amount of success or failure that young people encounter in the tasks that have to be faced during this stage of life. The risk of self-destruction heightens during adolescence. Suicidal aims may be in the service of separating from a world that seems to fail to appreciate one's unique qualities, to punish oneself for misperceived worthlessness, or to take masochistic revenge on significant others. The solutions one arrives at toward accomplishing the diverse tasks of this stage of life result in a self that is getting programmed for passing smoothly through all the subsequent aging processes.

Here we are concerned with how one lives through old age. An adolescent who used excessive ethyl alcohol or other drugs of abuse

to cope with the stresses of adolescence and win approval of one segment of the adolescent population will carry the biological scars of this abuse throughout life, and after adolescence has yet to learn to cope more effectively with the self and others. Besides dealing with the expected course of biological aging, as well as the cellular damage already wrought by the chemical substance abuse, the lingering psychological and behavioral adaptive deficiencies of adolescence have to be borne or modified. We know that a shortened life span, relatively early cognitive impairment, and vulnerability to certain degenerative diseases complicate senescence.

Considerable success during adolescence at attracting external approval and personal recognition through the achievements that one's society customarily rewards can lead to a comfortable and healthy sense of self-confidence that may sustain one through later adversities. In the instance of some achievements, however, such as in sports or in the performing arts, an adolescent may be led to a temporary overevaluation of the self and a regression to the grandiose self-concept normal for infancy and early childhood. These outcomes of aging during adolescence will affect the later course of life. To understand how and why different people are going through old age in such diverse ways, one has to know what happened during adolescence and the other previous aging experiences.

The effect of parental loss has now been proven to have a telling influence on subsequent emotional security and personal development. Many psychoanalytic studies, corroborated by subhuman animal studies in which the offspring were experimentally separated from the parents, have revealed that separation from parental figures are the psychosocial factors—possibly augmented by biomedical, including genetic, factors—that predispose offspring to be more vulnerable to affective disorders, such as unipolar or bipolar depressive disorders (Gottschalk, 1981). In a recently reported systematic study (Breier, Kelsoe, Kirwin, Beller, Wolkowitz, and Pickar, 1988), the effect of parental loss during childhood on the development of psychopathological disorders was assessed in ninety human adults. The subjects with a history of an adult psychiatric disorder, in comparison with subjects with no history of a psychiatric disorder, had a poorer quality of childhood home life and personal adaptive abilities (as measured by the Home Life and Personal Adaptation scale, developed by the investigators) subsequent to the parental loss. The subjects with an adult psychiatric disorder had biological markers of strain in the

form of significantly increased plasma levels of cortisol and beta-endorphin immunoreactivity in comparison to the subjects without a psychiatric disorder. Moreover, first-degree family history of psychiatric disorders, age at loss, and paternal versus maternal loss were not significantly different between the two groups of subjects, which indicates the significance and importance of the quality of the parental care after the loss in influencing the occurrence of psychiatric disorder.

THE AGES OF 20 TO 50

During this life epoch there are many big steps that the individual is expected to take in our modern world that can enhance or impair one's self-image. (1) Getting a vocation and earning a livelihood. (2) Pairing off with another individual, usually of the opposite sex, and learning how to have good intimate relations. (3) Deciding whether or not to have and to rear children; providing parenting functions, including economic and educational, for dependents if one has children. (4) Trying to maximize one's skills and productivity in some vocation. (5) Finding an acceptable position in one's local or larger community.

Men and women who do not have children and who do not become involved in parenting tend to have a different life course than those who do. There are fewer psychopathological disorders in childbearing males and females as they age, and the responsibilities of parenthood appear to promote emotional maturation (Gutmann, 1981), however, clearly not in every adult. From the viewpoint of a practicing adult and child psychiatrist and psychoanalyst, I get a different and obviously narrow perspective on such a statistic, or I become heavily engaged in trying to help adults solve their problems involving marriage and parenting and their underlying psychoneuroses, as well as the emotional conflicts that plague their children. How effectively these problems are remedied has a definite bearing on how well they all cope with what old age has in store for them. The variety of personality configurations dealing with the challenges accompanying old age seem to me, at times, to be more impressive than the common denominators typifying older people—except for the final equalizer that they all have to face dying.

THE AGES FROM 50 THROUGH 80 AND BEYOND

Late maturity and senescence bring further challenges with which an individual must cope. (1) Providing everyday economic support and other parenting functions for dependents. (2) Dealing with responsibilities associated with other goals when one has no offspring to rear and support. (3) Maintaining a sense of usefulness and a self-respecting place in the community that expects individuals to have a productive work role. (4) Coping with the problems associated with vocational retirement. (5) Dealing with the loss of members of one's kinship and social network by illness and death. (6) Coping with one's increasing mental and physical debilitation as one's age advances. (7) Coping with the prospect and eventuality of one's own death.

I have looked into some of these tasks in my previous discussions here as they apply to me. I am still engaged in supporting the continuing educational goals of some of my children, even though they are all over 35 years of age, because I chose to and regard continuing education as a virtue. I am coping with the prospect of vocational retirement by avoiding the whole issue. I do not take lightly the passing away of my kinfolk and friends; the topic preys on my mind by giving me vivid visual and auditory flashbacks of personal interactions and events, some of them through voluntary selection and some slightly intrusively through elicitation by ambient stimuli (time, place, or person) coming from my environment. My mind works like an analog computer, triggered to retrieve stored memories from my brain by events or objects similar to the memories—but often surprisingly dissimilar, the connection being vaguely metaphorical. On another topic, I have not yet had to cope with much physical or mental decline, if any, of my resources; I do not like to reflect on what I will do about them. This situation is something akin to how I deal with my automobile; I take good care of it, and I am not inclined to worry about what I will do if one or another thing goes wrong with it until it happens. The analogy has limits, of course, for I know that my automobile can, at any time, be completely replaced. The other tasks of senescence I am working on.

Recently I treated a 73-year-old man who complained of feeling depressed and anxious after five years of chemotherapy and radiotherapy for a form of chronic lymphatic leukemia. He was feeling discouraged and somewhat hopeless. He told an extraordinary life story of his family being ostracized by other Jewish families in the

village in Hungary where he was born because his father lost his job as a cantor. Then two of his sisters became street walkers because of family financial problems, and then the Nazis put him in a work camp and sent the rest of his family to a concentration camp. Later the Russians captured him and put him to work with construction crews in frigid weather under more stringent conditions than he had to endure as a slave-worker for the Nazis. His explanation of how he survived these terrible hardships was that he was not a stranger to economic privation and humiliation before the Holocaust. A sense of family loyalty and a conviction that he had already experienced the worst that could happen to him helped him develop a determination to carry on whatever the odds against him. He endured all these severe adversities, came to America, pursued a gainful occupation, married happily, and had a family. Although he had the devoted emotional support of his wife, the recurring setbacks encountered with the medical treatment of his severe blood dyscrasia was eroding his self-concept of invincibility. In addition to the debilitation associated with his leukemia, he developed terrible left-sided cephalgia and partial deafness that his oncological physicians thought might be lymphatic tissue infiltrated with the leukemic process or an adverse side-effect of the powerful chemotherapy he was periodically receiving.

The psychodynamics of this brave patient obliged me to concede that early life deprivations and hardships might actually serve to evolve protective strengths in the face of worse vicissitudes. He volunteered that he had witnessed many fellow Jews who had enjoyed a comfortable and safe family existence before the Holocaust passively surrender to or even elicit savage cruelty upon themselves by their Nazi tormentors. I noted that this patient responded to my attentiveness and sympathy about his serious medical condition with remarkable improvement of mood and relief of symptoms of pain and definitely increased hopefulness. As a mental health professional, I still could not generalize from this case to recommend planned hardships and tribulations for latency age and pubertal children of the degree suffered by this man. He died suddenly from a cerebral hemorrhage while undergoing an episode of chemotherapeutic therapy for his medical disorder.

Not long ago I had an initial consultation with an 80-year-old psychiatrist, who was accompanied by his wife. Both husband and wife had retired. She was enjoying the many activities available within their local retirement village. He was not becoming involved in these

or the potential social interactions. Rather, he was mostly reading and reflecting, and he claimed he felt he deserved to slow down some because for most of his life he had been "hypomanic" and, until recently, heavily involved in a very active private practice. Rather incidentally, he related that he had prostate cancer, colon cancer, a colostomy, the early stages of cardiac failure, and he had medical therapy for all of these physical disorders and was continuing to receive pharmacotherapy for his cardiac condition. With a faraway look in his eyes, he made the understatement that he did not quite have the energy level he used to enjoy, but that otherwise his mood was not one of depression. His wife felt he was depressed and his slowing down was atypical of him and psychopathological. He thought that his becoming more sedentary, somewhat less social, and slightly more introspective was appropriate. I made the peace-making comment to the two of them, strongly disagreeing with each other in front of me, that the truth of the situation was probably an average of what the two of them were observing, realizing as I said so that I was playing the role of a not very good diplomat. This tidbit of a case is mentioned here to bring home something I have neglected so far to comment on: the impact of the aging of one member of a family on another member. I recognized his wife was not prepared to accept her husband's mental and physical status. Maybe that was good for him, maybe not. I did not feel I knew them well enough to be a very wise counsellor. Both wanted something from me and had made their way through twenty miles of Southern California freeway traffic to find me.

These little cross sections of the nuances of life at the older ages are a forerunner of later chapters in the aging process when one or more persons becomes progressively disabled, as in degenerative arthritis, blindness, severe emphysema, or Alzheimer's disease, and the burden of care weighs heavily on the more healthy members of a family. In such situations, we can observe more obviously the interrelationships of the psychodynamics of the caretaking family member and the invalid.

The privately practicing psychiatrist and psychoanalyst, not unlike the proverbial story of the three blind men and the elephant, is in danger of witnessing a rather incomplete picture of the courses of aging from the viewpoint of social class. This was brought to my attention as I glanced at my *Wall Street Journal* not long ago one morning (Hagedorn, 1989). A subheadline caught my attention:

"Geriatric Convicts Get Prison With Ramps and Rails and Tomato-Plant Fights." Reading further, I saw: "The pink, green and mauve buildings of this former tuberculosis hospital have been transformed into what may be the wave of the future in American corrections—specially designated prisons for the elderly." Reading on: "a geriatric crime wave appears to be sweeping the nation. Criminologists attribute the apparent crime spree to the frustrations of old age in this country, among them poverty and feelings of uselessness. Murder, sex offenses and arson are the crimes most often committed by the elderly." We learn that a grandfather living with his daughter will murder his son-in-law or a dispute over a property line will lead to a neighbor being murdered. Or a grandmother, who has to raise grandchildren because the daughter has a problem with crime or drugs, will herself deal in drugs and maybe be imprisoned.

So, aging is occurring in all social classes and walks of life, worlds which many psychiatrists never explore. A great financial newspaper like the *Wall Street Journal* thinks that even the elderly in the prison population merit a feature article.

EVENTS WHICH MAKE GETTING OLDER MORE POIGNANT AND UNFORGETTABLE

I have just reviewed and discussed the process of aging through the different phases of the life cycle. This fairly comprehensive discussion, plus the preceding more desultory discussions, would appear to cover the topic as fully as I can. I am afraid, however, that like many other subjects dealing with such important phenomena of human existence, there is always one more matter that needs to be considered. One such matter that keeps coming to my awareness is the impact of the death of acquaintances, friends, or relatives on how one looks at life and the process of aging.

I have long been familiar with the emotional impact that dying and death have on the survivors. The diversity of reactions is incredible, and ranges, in my experience as an observer, from joy to despair and eventual suicide. To try to review and document this diversity here would be, I believe, encyclopedic and well beyond the scope of this chapter. A very good case could be made that the more one knew about a person's family, psychosocial history, life circumstances, their

present and past psychodynamics, and their beliefs, the more understandable would be that person's reactions to the death of a loved one.

A poignant experience for me, certainly affecting my aging, has been the death of the youngest of my four children, a daughter age 32, by the name of Susan. Being a gregarious type of human creature myself, much given to emotional attachments, just contemplating the demise of an immediate and even more remote kin was a mental activity I preferred to avoid—choosing the method of waiting until such an event actually took place than suffering anticipatory anxiety and/or grief. With respect to the death of my wife and any of my children and even more so my five grandchildren, I am totally unprepared for how to cope with such a catastrophe. I was forced to deal with something of this sort when I was informed of the death of Susan on November 15, 1987, by her own hand.

This is not the place or occasion to relate my overwhelming grief—a grief that is now well manageable—for the point here is to contribute to how such events influence the process of aging. I believe that such a subject matter has a place in this series of discussions, for if one lives long enough everyone experiences in a lifetime some kind of tragic event or events. I have already noted earlier in this paper those factors that appear to make one more vulnerable or less vulnerable to the impact of such events.

Susan was a well-educated young woman (a college graduate with a bachelor of arts, with a major in writing and the humanities, plus a master's degree in business administration), who was well known locally as a mother and an innovative artist, photographer, and writer. She had been married for eight years and then divorced from a capable and well-educated musician with a master's in music, a cellist, by whom she had had a son, Hampton, 9 years of age at the time of her death. She kept a detailed journal of her life for many years.

In her journal, written both in prose and in poetry, she revealed her initial love and idealization of her husband and his talents. These sentiments were followed by a gradual sense of disappointment that he did not correspond to these ideals, for he was not able to earn a self-respecting livelihood as a cellist, his visionary efforts to develop some other means to support economically his little family and his lack of appreciation, if not covert envy, of her own creative talents. Her progressive disenchantment with her husband and her assuming

more and more the role of a wage earner in the marriage led eventually to a divorce. The custody of Hampton was put in the hands of Susan, which she managed well through the assistance of a warm and cohesive extended family, namely, her own and her ex-husband's parents, her own married sisters, and a married brother. Susan achieved more and more recognition in Southern California as a very original poet, artist, and photographer. Learning she was no longer attached to a husband, many men tried winning her affection. John—a gifted and financially secure artist—became quite devoted to her and sought to marry her. Susan was hesitant because her son for complex reasons had reservations concerning John as a stepfather. Andreas, a German-educated engineer and citizen, wanted to marry her and live with her and her son in Germany. She was reluctant to do so after spending an extended period of time with Andreas in Berlin where he worked and lived. She did not want to rear her son in Germany. Besides, charming as Andreas was, she did not like his getting drunk when he was in a depressed mood. There were other suitors enamored of her: Tim—a childhood playmate, a computer scientist with a doctorate from the Massachusetts Institute of Technology; George—a physician in specialty training. And there were others. None of these did she want to chose as a permanent mate. It was Bill—an Army Corps retiree, younger than she, trying to make his postmilitary career in a defense industry—with whom she fell in love. They had a passionate love for one another. Bill and Hampton, her son, liked each other. A June wedding date was set for the marriage ceremony at her parents' home. Her life was turning out to have a happy course.

Then Matthew, a close friend and photographer and artist with whom she shared artistic interests, developed AIDS. Observing him go through the painful throes of dying stimulated her to start writing a dramatic production concerning dying. She found herself having difficulty with the existential aspects of life and in coping with the death of loved ones. One afternoon shortly before Matthew died and more than a year before she died, she asked me how I coped with the death of someone I loved because she was having a hard time handling Matthew's dying. I said, seriously, grief was hard work and took a while, adding—clearly too casually—that she could survive the pain. About this time an argument ensued between Susan and Bill about where they would live after they were married—he worked some 100 miles away from where she lived and where her son was attending

elementary school. Their dissension escalated over time, which led to a postponement of their June marriage, followed by several periods of friction and reconciliation.

On top of this Susan had to have a surgical operation on a bursa over her hip to relieve chronic pain resulting from a ligamentous strain she developed while living in Germany with Andreas. It was a few weeks after this surgical procedure that Susan ended her life—hiding her intentions of doing so from all the members of her family. In her suicide note she said that between her problems with Bill and the memories of Matthew's dying and the slow postoperative healing, she had lost patience. She wrote that she had lived more actively and seen and done more things in thirty-two years than most people. She did not want Bill to feel any blame.

Bill was devastated with guilt by Susan's death. He reasoned that if he had merely regularly commuted to his workplace instead of insisting that she move away from her home of long standing, she would still be alive. I suspect there is much more to this story than I am aware of or understand.

My funeral oration expressed my sentiments at the time, and I could not prevent the tears behind my eyes from coming out as I gave it.

We are talking about a death that took place November 15, 1987, and today is December 26, 1992. Many times per day since then I am reminded of Susan—frequent visual and auditory memories come to one from her whole life story and her death, and the grandson she left with us. I suspect that the memories of these events and their easy presence on the surface of my consciousness is a natural result of my professional habits as a psychiatrist and psychoanalyst. Psychoanalysts are not supposed to suppress feelings and memories but rather to foster their retrieval and awareness. I am sure that many other occupations encourage the suppression and inhibition of feelings and the easy retrievability of memories; for that reason alone, I believe my own personal experiences in reaction to this traumatic event will not be widely generalizable to other individuals. They will, however, be plausible, I hope, and my tolerance of the emotional pain and capacity to recuperate may serve to illustrate some personality factors that predispose to carrying on with dignity in spite of nearly unbearable distress. An academic friend of mine conjectured that my being an elderly person helped me sustain this loss. I do not believe, at least in my case, that old age has been any advantage whatsoever in my coping

with this tragedy. The poignancy and ubiquity of the memories and their associated affects I experience are pervasive. Yet they are not overwhelming. They have a ready place in my state of consciousness. They do not cancel the immediate pleasures of living. They punctuate it with sadness and grief, and yet, more and more, with bits and pieces of pleasure and joy when I recapture the happy moments we shared and the great creative achievements that were Susan's from her birth to her death.

The psychopathogenesis and psychodynamics of Susan's death are largely self-evident. A genetic component of her suicide is not likely for there is no record of suicides or major mental illnesses on either side of Susan's family for as many generations as we can go back (three to five generations).

The many art works and writings that Susan left behind were, at first, painful reminders of her passing. As times goes on, the capacity of these creative works to remind evokes increasing pride and approval of her creativity, mixed with a twinge of melancholy that I cannot talk to her or hear her anymore directly or see her beautiful freckled face and red hair. A portrait of her and many photographs of her throughout her life give the illusion that some posture or action of hers has been forever captured in immutable form. This illusion brings on an evanescent sense of comfort.

Sometimes I find myself adapting my incorrigible rescue mode. Why did I not recognize what she was considering doing? Why did not other family members or friends do likewise? How could she do this to herself and fail to share the grimness of her outlook with us? Why was I so stupid to miss the signs? She rebuked all of us by her final act for being amiss with respect to helping her in one way or another. And then the pain of grief is likely to resume.

I know for sure that as I age the misfortunes of all my children (and now grandchildren) affect me strongly, as well as their successes and happiness, no matter how old they are or whether or not I could have conceivably foreseen or influenced the course of their destiny. For while I am programmed to nourish, protect, and foster their success on this planet I know I must gradually let go of their umbilical cords and learn to stay out of their way so that they can become autonomously strong and make their own way in life. Yet as a parent and grandparent I must make myself available to any reasonable request from them.

Losing a child has highly sensitized my capacity to perceive better the needs of my patients, my friends, and my family and to gauge better when I might wisely offer or not offer myself as a helper. The experience has also again taught me my limitations in predicting, discerning, and changing human behavior without erasing my conviction that I am, ordinarily, a competent psychiatrist and psychoanalyst.

I do not intend to ignore that there are experiences one does not forget or want to forget that are joyful and sustaining and make life an exciting and wonderful adventure. Loving, childbearing, parenting, and beauties of nature, art, music, science, the creative process, work, play—these and more constitute the strengths and pleasures of our memories and neutralize or cancel out the pains that come with adversities. These experiences promote our enthusiasm and hope in progressing through each stage of the life cycle and aging.

There are undoubtedly countless unforgettable and poignant experiences in a person's lifetime that leave indelible marks on one's mind. I have cited some that have affected me and are continuing to influence the course of my aging, in order to illustrate the kinds of mental processes that everyone will experience in a lifetime. The very disturbing and unforgettable event or events we humans may experience and have to live with are quite varied. They include the effects of human personal tragedies (crippling accidents, disabling illness, parent loss, criminal victimization), the horrors of wars, the influence of catastrophes (hurricanes, earthquakes, famines, floods) are a few of the life experiences whose memory traces may plague an individual during the course of life. It is enlightening to learn that some individuals somehow take these experiences in their stride, whereas others are more vulnerable. Most of us have a predominance of gratifying and sustaining life experiences that help us cope with the burdens we encounter.

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2

Experiencing Aging: Separation and Loss

Alex H. Kaplan, M.D.

DEFINING AGING

Before discussing my own experience of aging, it makes sense to try and define aging if that is possible, since the topic can be defined from the viewpoints of the biological and constitutional, the psychological and behavioral, and the social and cultural. In essence such a multifaceted approach is best described as biopsychosocial, a concept described in 1963 (Kaplan, 1963, p. 499). It is of interest that while the seventh Webster's *New Collegiate Dictionary* defines age and aging as becoming old, to show the effect or the characteristics of increasing age, a second definition describes aging as becoming mellow and mature (like cheese and wine).

A more helpful and all inclusive definition of aging which incorporates most of the features of aging that I will be discussing was outlined by James E. Birren, who defines aging as "the transformation of the human organism after the age of maturity—that is, optimum age of reproduction—so that the possibility of survival constantly decreases and there are regular transformations in appearance, behavior, experience and social roles" (Birren, 1988, p. 159). The most common hypothesis defines aging as:

> (1) a result of disuse of previous skills or capacities; (2) a consequence of random wear and tear; (3) a consequence of selective reinforcement

> by the environment leading to decrements or increments in adaptive capacity; (4) a loss of resources; . . . (5) a consequence of genetic control over later-life characteristics; . . . (6) a consequence of individual choice and creation of new problem-solving solutions that may have never been seen by the species [Birren, 1988, p. 160].

However, even after defining aging in such a global fashion, there is so much subjectivity in the concept that despite the increasing number of facts available about aging, the experience itself is personal and idiosyncratic. From the standpoint of the psychoanalyst who writes of his experiencing of aging, his essay will not be a reconstruction but a narrative since the essayist is also the actor in the drama and, as has been the case throughout life, is subject to forces within and outside of him in the here and now. As Pollock has pointed out:

> As we learn more about genetics, prenatal organizers of personality, unique dimensions of adult and later adult functioning, we may need to revise our existing ideas about developmental progression. For example, we have firmly believed that specific consequences have precise antecedents, that later life solutions and approaches are intimately linked to earlier events. While accepting these premises, the danger that everything can be explained by the events of early life may hamper our efforts to find unique features of later life that may not be exclusively explained and tightly coupled with the traumas and resolutions characteristic of infancy and early childhood [Pollock, 1981, p. 554].

EARLY FACTORS AFFECTING MY LATER EXPERIENCING OF AGING

I am now just past 80. Before I was a year old, my father left the family to immigrate to the United States, the plan being that the family would later join him. Just before my second birthday the family was reunited. This was my first major separation. At that time, I was the youngest of three boys, my next older brother being only 15 months older than me. There are few personal family events, especially with my mother, that I recall before the age of 9 when my mother died very suddenly. This very traumatic loss had serious consequences for me, since my memories of events before that time have been permanently clouded. I cannot revive any memories of my mother, and I can recall little of my experiences with my father.

However, there are a few specific incidents prior to the age of 9 which I do recall that indicate I was a very active, healthy, somewhat naughty and mischievous youngster. I was rivalrous with my next older brother who was more laid back, an attractive blond, more conforming but less athletic than I was. I can recall getting my brother into trouble by virtue of my greater speed and cunning. During our school years, I was frequently skipped into his grade and we graduated almost at the same time from college. I want to emphasize my use of physical activity, competitiveness, and occasional impulsivity as early personality characteristics. A fourth brother was born some four years after we were reunited (six years my junior). I have no memory or feelings regarding his birth, but do recall feeling the need to admonish him when he was older, like a strict father. After the age of 9 my oldest brother, over four years my senior, was my surrogate father with whom I closely identified. We went to the same undergraduate college as well as medical school, and I roomed with him in my first year at medical school.

Separation, loss, and the fear of dying became a frightening reality after my mother's death. However, the memories of the events just prior to and after the death of my mother are sharply etched in my mind. During a happy family summer vacation which included other family relatives my mother became feverish, toxic, and withdrawn from her children. There was a hasty return home and she was immediately hospitalized. We were not able to visit her in the hospital, and received no understanding about her illness except that she was desperately ill.

Following her death, my mother's body was prepared for burial in the living room of the house in which we lived. My bedroom was next to the living room and that night I had nightmares and chilling anxiety reactions with insomnia. The religious ceremonial cutting of my clothes as we all walked around the body was reacted to as an attack on my body and the ride to the cemetery and the burial was fearfully endured. When we returned home, in accordance with religious custom, all pictures and other reminders of my mother were removed. However, what was most traumatic was the lack of communication from my father about my mother's illness, her expressed wishes and feelings about us as well as his intimate feelings about her. I have no doubt that because of my activity and naughtiness, I experienced my mother's death as a punishment for my behavior. It

was only much later in my life that I understood my father's behavior, since I learned that my mother died of a postabortal peritonitis.

Following my mother's death, the nightmares continued for a time, and the anxiety I experienced, especially when I was enjoying myself in a family group (a reaction to the fear that closeness and gratification would lead to a serious trauma and then separation and loss), also went on for years. My own personal guilt is confirmed by the fact that I never discussed my fears with the family. Communication regarding my mother diminished further, after my father remarried, within a year of her death, a kind and devoted older woman who had previously been our homemaker. Although my stepmother and father were very busily involved with the children, they were not capable of close and intimate relationships.

Before the age of 9 my early feelings of my sense of self and my relationships with my parents and siblings were reasonably secure, despite my rivalry with my next older brother and the threat of the new baby. I felt vigorous, physically active, and happy. Following the death of my mother, in my mourning response I became rigorously active physically, more competitive at home and at school, less able to be open, dependent, and trusting with family and friends. My overassertive behavior acted as a selfobject function which protected me from close affectionate relationships with which I had associated the possibility of death, separation, and pain. Even my analysis could not revive the lost feelings and memories from before the age of 9. This may have been a factor of the analysis itself since the transference aspects were not attended to. Instead the primary concern of the analysis was a probing of the past. More of this later on.

Despite my parents' devotion to their children, the lack of intimacy and close supervision resulted in a significant bonding to all of my brothers. Strongly identified with my oldest brother who is also a physician, I was rivalrous but close to my next older sibling, and supportive of, but strict with, my younger brother. We slept together in double beds, ate together, studied together, went to the same schools, played together, and were major emotional as well as financial supports to each other. The intactness of the sibling unit, and the close physical and emotional intimacy with each other, served to gratify my relational needs and selfobject identifications. The gratifications from the intactness of the sibling unit served as a healthy selfobject function for me, to overcome the threat of death and separation that I had

experienced. In other terms the bonding was the result of the mourning-liberation process described by Pollock (1977). But, despite the reparative aspects of the sibling relationships, I was still tentative in close relations, and used my activity to plunge ahead competitively toward new goals to gain more sense of my self.

My anxiety episodes and my fear of my own death faded away in my late latency period and my adolescence. As a teenager, I was personally involved with the death of three grandparents. However, I was not very close to them and did not feel much grief or suffering at the separation. If I was protecting myself from my reactions to the death of my mother, I was not aware of such reactions then and now. It is of interest that as an intern and psychiatric resident, I pronounced many patients dead after the fact, but I never actually saw a person die until I sat at the bedside of my brother-in-law several years ago and was deeply affected. While such past behavior may be related to my own personal history and fear of death, such actions by physicians in those earlier days were the rule rather than the exception.

EVENTS LEADING TO MY EXPERIENCING OF AGING

In my early years I could not wait to be older. I was usually the youngest child in my class and also one of the smallest. When I was in college I was as old as most high school students. One incident in junior high school is still vivid in my mind. There were several orphans at the school who lived in an institution. I always felt jealous of them because they were served cookies and milk when they returned from school. This illustrates the underlying emptiness I must have felt at that time even when I was 11 years old. Immature socially as compared with my peers, with a diminished self esteem, I was always filled with thoughts of being older and more competitive with my classmates. Even at 9 I wondered if I would be alive in the year 2000. This meant that I would have to live to the age of 88, but in my fantasy, I was sure I would make it. Obviously, this was a comforting thought to counter my concerns regarding separation and loss.

My adolescent maturing processes began in my late years at college and medical school, and the aging process was of no concern to me. I sprouted a mustache during my medical and early professional

years because I looked so young. Death and aging did not seem possible to me at that time of my life. While uneasy about new beginnings I welcomed them as a challenge. By plunging ahead in new situations, I was trying to gain more sense of self. I followed in the footsteps of my older brother. I was a freshman in college when he was a senior, and a freshman in medical school when he was a senior. At least for the first year of two important new situations, my brother was available to cushion my adjustment.

My marriage after graduation from medical school may also have been impulsive since we had no money of our own and little support from others. However, the marriage unit was as important to me as the earlier sibling unit. The choice of my psychiatric profession was also impulsive, but I am sure there were good, albeit unconscious, reasons for it. During my first year of psychiatric residency I met a senior resident who was enrolled in psychoanalytic training. His acute perception of the underlying psychic conflicts in the patients we saw and his interpretations of their behavior created some unease about my introspective capacity and resulted in a loosening of my emotional defenses. Identifying with the senior resident, a substitute for my older brother, I applied and was accepted for psychoanalytic training, but never felt when I began my analysis that I had any personal emotional problems.

I recall a patient I presented at a case conference in my first year of psychiatric residency. She was 35 years of age and in my innocence I described her as a middle-aged woman of 35. There were many laughs and protests from the audience, all of whom were older than the patient. When I was queried about my description of the patient I blithely pointed out that 35 years of age was half of 70, a ripe old age. I was 26 years old at the time but quickly learned that middle age as well as old age is usually ten years older than your chronological age. Certainly I never thought of aging at that time. When I was in the military, I applied for overseas service, never paying much attention to the fact that I had a wife and three dependent children, and should never have thought of leaving home. Be that as it may, my service in the Second World War was liberating for me. I had an enviable research position and the salary and accommodations were far superior to what my family had previously enjoyed.

Looking back at my choice of profession, I entered the field of psychiatry and applied for psychoanalytic training to understand my

emptiness and unease and my fear of reaching out for intimacy. However, at the time of my analysis I was not aware of these feelings, nor did I become aware of them in my analysis. The analysis was carried out in the late 'thirties. While the concept of transference had been described much earlier, it had no part in the analysis. In the analysis, we searched intellectually for past memories and feelings which rarely surfaced and when they did were not related to the transference. The relationship between me and my analyst was never a subject for the analysis. I never came to terms with my feelings for my analyst, and termination was devoid of any feelings. Even the reaction to the traumatic death of my mother was an intellectual one in the analysis. The clouded past was never clarified. For the most part my analyst was silent. Interpretations were sparse and did not involve the evaluation of the transference and countertransference. The analysis was a failure of theory and technique and allowed me to continue to maintain my defenses. Following my analysis and graduation from an institute, there were years of self analysis, side effects of my own therapeutic endeavors, peer supervision, and readings in psychoanalysis. As a result, some of the memories and feelings from my past were slowly reacted to with mutative changes in my personality.

The private practice of psychoanalysis was very successful from the start and I was involved in administrative aspects of psychoanalysis and psychiatry, as well as teaching. My thirtieth and fortieth birthdays were greatly enjoyed with little or no thoughts about aging. When I was 41, I developed some back difficulty just before embarking for our first European vacation. This cleared up in several weeks. While this illness must have been of concern to me, I denied it to myself and others and worked very hard physically to overcome the back problems.

In my late forties I began to develop prostate difficulties and made frequent visits to the urologist. He was an overly protective physician and lulled me into having little or no concern about my health. My fiftieth birthday was a disturbing one for me. I could fantasy that the age of 40 was half of eighty and I comfortably felt that I would live that long, but such a fantasy was not possible at the age of 50. Somehow 50 years of age was a crucial landmark for me. Life could not begin at 50; it was all downhill from this point onward. Our oldest child was married and was soon to have our first grandchild, an event about which I was happy but which also indicated

that I was aging since I now belonged to the third generation. Notwithstanding the fact that most people in their fifties were making funeral arrangements, it never occurred to me that such an action was necessary. Even at my present age, no specific funeral arrangements have been made. My occasional thoughts about aging or my denial of the aging process and my possible death began in earnest after the age of 50.

My chronic back difficulties led to an emergent back operation when I was 58, and my prostate was removed when I was 60. The removal of the total prostate was predicated on the assumption that I was a very young 60. I recall that I was told that the so-called normal prostate had a few cancer cells, but again responded to the denial of my urologist and my own denial, not to be concerned. Residual urinary problems have persisted to the present time, but throughout the next fifteen years before the prostate cancer returned, my denial was so great that I had little concern that the cancer would return. I never did search the literature or become acquainted with the basic knowledge about prostate cancer. Looking back at those years, my defense of denial was considerable and I reacted against my fears with even more physical activities. Even the back operation did not keep me from the tennis courts and I meticulously exercised each morning to keep my body in good shape.

REACTION TO CONTINUED PHYSICAL DISORDERS

My lack of concern and denial of my prostatectomy when I was 60 indicated that I still needed to maintain my feelings of physical intactness which had served me so well in the past as a selfobject function. These feelings had protected me from the unease I might have developed if I had allowed myself to accept the fact that I was aging (further separation and loss) and had to accept my increasing dependence on others which in the past was too uncomfortable for me. Since that time, as might be expected, there has been constant and continuing physical deterioration. A detached retina was repaired in my late fifties; I developed cardiac arrhythmias in my early sixties. Side reactions to drugs taken as treated for my cardiac difficulties were frequent. I have developed dizzy spells, and there is more cardiovascular distress while exercising. But despite these reactions, I have continued to maintain my physical activities with the hope that

by struggling against the decline of my bodily powers, the aging process will be slowed. My eyesight has become impaired, not only as a result of the detached retina but also as a result of other aging changes. My hearing has also been impaired at an increasing tempo necessitating hearing aids in both ears. But throughout these years there has been much less denial, and I have been taking all of the responsibility for my illnesses and their treatment. I routinely research the literature, make my own choices of physicians, and participate in treatment procedures. In the process of these emotional changes I can now allow myself to be more dependent without feeling demeaned or diminished.

The most recent trauma was a return of the prostate cancer. At this point, since I was already assuming responsibility for all of my physical difficulties, I took charge of the new illness. I rejected the advice of my overprotective urologist who suggested no treatment for the new cancer. However, this time I did an extensive search of the literature and saw three other urologists for consultations. Despite the fact that each of them offered different solutions to the problem, I finally made the decision to be treated by radiation and, when that failed, surgery.

Asserting control over my body was my attempt at mastery, but my actions also allowed me to accept the severity of the situation and to rely on others without denial or hypomanic physical activities. Following the radiation therapy and surgery I became anxious and depressed. I know that fundamental changes are taking place in my personality and my attitude to my aging and possible death. When I was first operated on for an enlarged prostate and earlier for my back difficulties I was later told by my wife that I was moderately depressed, but at that time I was personally not aware of those feelings. Pollock's description of the mourning-liberation process closely captures my own reactions to the return of the prostate cancer as well as all of the other bodily changes occurring between 65 and 80.

> In dealing with aging issues, I have found the focus of the mourning-liberation process to be of great importance. The basic insight is that parts of the self that once were, or that one hoped might be, are no longer possible. With the working out of the mourning for a changed life, lost others, unfilled hopes and aspirations, as well as feelings about other reality losses and changes, there is an increasing ability to face reality as it is and as it can be. Liberation for the past and the unattainable occurs. New sublimations, interest and activities appear. There can be

> new relationships with old objects as well as new objects. Past truly can become past, distinguished from present and future. Affects of serenity, joy, pleasure, and excitement come into being [Pollock, 1977, p. 596].

While others may have considered me as elderly, I know that for a long period of time I saw myself as healthier and younger than I really was. There was still the narcissistic need to think of myself as young and healthy. I know I took great pride in the thought that my skin was supple and my joints still were in decent shape, or that I never had to use supports for my back or my joints when exercising. One incident comes to mind to illustrate this attitude. I took several grandchildren, grandnephews and -nieces to a large theme park. Besides many rides and comedic activities there was a young lady who wagered that she would guess my age by two years. If she failed to do so I would receive a prize. I was confident that I would win the prize since I felt I looked at least ten years younger than my chronological age. To my astonishment and chagrin, she guessed my age correctly. This was a significant corrective emotional experience as well as a major blow to my narcissistic pride. There were other such experiences, such as people offering to help me get out of a boat, or admonishing me when I walked on a narrow ledge or cautioning me from undertaking too strenuous physical activities.

However, I was still able to be active in sports and even compete successfully with my children and grandchildren. But fewer persons were as interested in playing tennis with me and the number of available players has diminished. Slowly I have become less involved with the intense need to be so physically active. Walking has supplanted running. These insults to my self esteem are being slowly resolved as I become involved with intellectual pursuits since I feel that my mind is still intact despite my declining physical powers. In addition, there has developed a greater comfort in close intimate relations with family and friends. I am allowing myself to be more dependent on others without feeling diminished or being fearful of being rejected. These mutative changes in my personality, which are now more apparent and have occurred during my aging process, could not have come about without the continued support of my family, friends, patients, and peers. These relational interactive developments occurring during the aging years have facilitated the mourning-liberation process and allowed for mutative changes, similar to what happens in therapy.

REACTIONS TO DEATH AND DYING

I recently checked with my older brother and he agrees with me that there was a conspiracy of silence about my mother. Years later, my maternal relatives who had continued to maintain a relationship with the family filled us in on many of the details about my mother of which I had not been aware. They were as surprised as I was that we knew so little about my mother during her years with us, as well as her earlier life. She was described as an assertive, highly intelligent, independent woman who was sensitive, caring, and affectionate.

The anxiety reactions that began at my mother's death continued until I began to develop my own death-threatening disorders and underwent several major surgical procedures. After the prostate surgery, I was bleeding so badly there was a concern for my life. As physical changes have occurred over these past twenty years, and the real threat of dying has become an everyday event, my past anxiety about the fear of my own death has ameliorated in parallel to the improvement in my ego strength and self-cohesion. The threat of dying is always present in my mind but I am not as terrified. I sometimes think of how nice it would be for me to be some thirty to forty years younger but I never fantasy being a young child, an adolescent, or a young adult. Those days were filled with too much unhappiness and frustration. But most of the time I am not sure I want to go around again. I have no religious feelings and essentially feel that I am alive by some accident of fate and that life has no special meaning beyond what we make of it. Death is separation, and earlier I felt it was a punishment, which probably was the etiology of my earlier anxiety attacks. Separations from my loved ones are more muted now. Several years ago, my next older brother died. He had become highly successful in a creative educational corporation and published many books on the personality development of young children. Although his activities were similar to my interests, for many years I was no longer competitive with him but felt simply proud to be his brother. He had a long period of declining health, but the mourning process for him was muted. More recently some of my close friends have died and some are very ill, as is my wife. Soon, I will be the oldest of all my relatives. While I cannot realize my own death I do worry about pain, long suffering, and extreme helplessness.

On the other hand, when I am ill I still do try to take care of myself and may still be counterphobic about my physical activities,

insisting that I continue to be more active than is good for me. I hate the idea of leaving this world that I have lived in for so many years and still wonder if I will make it to the year 2000. Since I have not yet made my funeral arrangements, I obviously am still ambivalently denying the possibility of my death.

The experiencing of my aging and my death is also tied up with the serious illness of my wife who discovered some years ago that she was suffering from ovarian cancer with metastases. The history of her illness, several major operations and frequent periods of chemotherapy, some administered far away from home, has much to do with my altered feeling about my possible death. My wife is well aware of her condition and we have come closer together as a result of both of our illnesses. We have shared our feelings about our impending deaths, written our wills, and discussed our past and present involvements with each other. At times, our conversations about dying have a comical aspect since there has been so much open communication with mutual support for each other. Each day is another day we have together and there is more gratification in the time we spend together, even greater than in earlier times when we both were more actively involved in our professions, family, and friends and I was more guarded, less trusting, and less open with my feelings. We have both become more involved with family, children, grandchildren, and now a great-grandson. It is clear that at this time in our lives, our professional interests and friendships are becoming secondary to our basic family interests.

SOCIAL AND CULTURAL ASPECTS TO MY AGING

Some years ago I had undertaken to help two married psychiatrists from the Soviet Union to become established in the United States. In the process I met the wife's mother who also immigrated with her children. Near the age of 60 she looked and acted fifteen to twenty years older. She looked old and felt old. In my discussion with her, she told me that women over 55 in the Soviet Union were pensioned off and considered elderly. All her life she was conditioned to expect to be elderly after the age of 55, when she was pensioned and stayed home to care for her grandson. In the next ten years in the country she became younger looking and also felt much younger. Obviously the culture in which one lives has much to do with one's attitude

toward aging. Most people have comfortably accepted me as a senior citizen but without diminishing me, long before I was ready to accept myself as being elderly. In my early sixties, when discounts were available to me in stores and movies, I was asked to show evidence of my age. This, of course, enhanced my pseudosense of self and supported my fantasy of being much younger than my chronological age. But in a few years, no one asked for proof of my age. Looking in the mirror corroborated the reality of people's response to my aging and also I began to see the face of my father, which consolidated the reluctant acceptance of my aging process.

Younger persons reacted to me as being elderly by offering to help me at work and at home but at the same time there was great respect for my "wisdom." Several years ago in accordance with Institute policy, when psychoanalytic candidates were asked to express their evaluation of a course I gave them, they referred to my age as a potential reason for my poor teaching efforts. This was an ageist remark, one of the few I have encountered in my career. It is of interest that at the time I felt I was detailing a new and advanced concept in the understanding of the obsessive-compulsive disorder. The same candidates were critical of other instructors but never mentioned age as a factor in their evaluation.

While this and the earlier incident at the theme park were narcissistic blows, they also were helpful in forcing me to accept my aging. During this period, I was asked to participate in oral histories, not only by my family, but in connection with my past involvements in psychoanalytic education and the development of a psychoanalytic society and institute. Over the years my brothers and I have taken pictures of each other, but in the past ten years my children have insisted on taking these pictures as part of a family history. Videotapes of myself and my brothers were also insisted upon to preserve family history and audiotapes were also encouraged. All of these incidents were helpful in consolidating my identity as being older. What also proved to be constructive to me was the opportunity these activities gave me to review my life history. Many affect-laden incidents were brought up and this allowed me to reexperience cognitively and emotionally both my early traumas and gratifying situations as well. This has been true of my experience writing this paper. It has been said that the elderly review their pasts but mythicize their remembrances. I have tried to be very careful not to give in to temptation. In all of these activities relating to a review of my past, there has been much

gratification at the warm and loving responses from family, friends, and associates which were most helpful to my sense of self.

Viederman, in discussing the usefulness of a psychodynamic life narrative in helping patients with physical illness and depression, expanded these thoughts in regard to all crises:

> It is important to emphasize that in a crisis individuals are not only vulnerable but susceptible to significant change. There is considerable evidence to suggest that important personality changes, reflective of changes in the representational world (modification of self and object representations), can occur during periods of crisis in a facilitating environment, one that solidifies the individual's view of himself as diversity [Viederman, 1986, p. 145].

In Erikson's last stage of development, integrity and despair, there is an acknowledgment of the development of wisdom so long as the senses are not impaired. He affirmed that later age-specific developments are dependent on the strengths of earlier years. But as the leeway of independence becomes naturally constricted there can also develop a "wise" choice of involvements in vital engagements which are of potential value to a society of the future (Erikson, 1984, p. 163). Kohut has also felt that wisdom was a mature endpoint of the development of the transformation of narcissism (Kohut, 1966, pp. 243–272). I have experienced people's interest in my "wisdom," not only in my practice but in my contacts with my family and friends. Many people have praised me in relation to my professional and family activities, and I do feel prideful about my accomplishments. However, inside I do not feel myself as others see me. Sometimes I feel they are talking about some other person. I suspect I still see myself with all earlier ambivalent feelings about myself, as a child, adolescent, and young adult.

AGING AND THE PRACTICE OF PSYCHOTHERAPY AND PSYCHOANALYSIS

It has not been unusual for patients over the past ten years or more to raise questions concerning my age and my intentions as regards retirement. They have expressed fear of my death, especially when I am away from my practice for various illnesses. As part of their fear of separation, they have also expressed much concern over what my

wife's illness will mean for the continuation of my practice. Eissler has expressed the feeling that psychoanalysts have avoided accepting the reality of their impending deaths, and as a result have created countertransference resistances in treatment. While the patient's concern over the aging of the psychoanalyst may be used as a resistance in therapy, there is also a reality that needs to be addressed. Eissler suggests discussing possible referral sources on an ongoing basis (Eissler, 1977). I am in agreement with Eissler, and when the patients' concerns regarding my aging seem appropriate, we have openly discussed potential referral sources in the event of my death, retirement, or incapacitating illness. In addition to the above, I stopped taking analytic patients when I reached the age of 70.

The awareness of my wife's illness raised diverse transference reactions. Two younger analysands who were having difficulty terminating flatly stated that they would never leave treatment because of my need for their support, as long as my wife was sick. In the early stages of her illness, they were deeply concerned as to the outcome of her treatment and her prognosis. However, their concerns were also used as a defense against their own fears of termination. One older woman patient had much concern over whether I would be retiring because of my wife's illness but later became aware of her hope that with the death of my wife, I would be available as a lover or spouse. It was necessary with several patients to enforce restrictions in regard to their obtaining information from other sources about my wife's progress. While I initially did not deny the seriousness of the situation, I did not respond to their questions concerning my wife's health. Many of these patients' responses occurred during a period of over four months when I was accompanying my wife for treatment out of town (Kaplan, 1992).

The problem of retirement has become an important internal issue with me. Information which I collected for an address to lawyers on retirement indicated that few professionals retire voluntarily unless they are sick. Not until the age of 75 did most lawyers and other professionals even consider the possibility of retirement. Many professionals at that time have a diminished pratice but are still active. More recently I have also begun to consider more actively the possibility of my retirement from private practice even though I am still physically and mentally able to continue and could have a full practice. However, by not taking referrals my practice is slowly diminishing. At this stage of my life I have the wish to be more active in areas which do not

include the treatment of patients. Retirement is generally a problem for those individuals without a good sense of self. But at this time I feel the acceptance of my aging has allowed me to consider total retirement from my clinical practice.

ARE THERE ADVANTAGES IN AGING?

Many authors have extolled the aging years as the "Golden Years," pointing out the many advantages of this phase of development and I do feel there are such advantages. However, implicit in such golden years are three major assumptions. They can be summed up in three simple words: *healthy, wealthy*, and *wise*. Given a healthy body, sufficient finances, and intact senses, there are many positive aspects to being older. I have already used my aging to give up many responsibilities. I have refused assignments as a discussant of papers as well as teaching assignments. I have given up administrative responsibilities and have arranged for longer lunch periods and longer vacations. I now start my practice later in the morning and finish earlier in the day. There is more time for reading, physical activity, and relationships with my family and friends. I now find more time to write and still have time for rest and relaxation. Also, as noted earlier, I am more comfortable being dependent on others without feeling diminished. I am much less ashamed of my emotional reactions and less concerned about public opinion. I feel more comfortable supporting unpopular causes.

Older persons are often described as being more conservative, frequently adhering to the past with no new ideas, but Simone de Beauvoir has described many artists and writers who have remained unusually creative into their old age despite the breakdown of their bodies (de Beauvoir, 1972). Freud continued to write and be creative until shortly before his death. However, as the deterioration of my body increases, I more often refer to the "Rusting Years" with their disturbing consequences, despite my continued comfort with my senses.

THE PSYCHOLOGY AND PHILOSOPHY OF AGING

There are many problems in the aging process. Without health, sufficient finances, and the preservation of one's senses, the problems of

the elderly are overwhelming. But given the three necessary ingredients for a happier aging, the basic psychological problem is how to learn to be dependent without losing your autonomy and basic sense of self. Inevitably, I must eventually become dependent if I continue to age but how I accept that contingency will depend on the strength of my autonomy and sense of self as well as the emotional relationships I have with significant others. The strength of my sense of self is also correlated with the development of a healthy narcissism. Many of my earlier defensive gestures as regards my aging were pseudonarcissistic defenses. I acted earlier as if my achievements in the area of physical activities would defend me against the inevitable aging process. Keeping knowledge of my various ailments from most of my friends and relatives is another instance of pseudonarcissistic behavior. The regressive behavior occurred at a time when my need for physical intactness was the selfobject function that maintained my pseudosense of self. After all, as an older person, I could still fantasy that I was still the young child, the teenager, the adult and middle-aged person I had been in the past. While I am still ambivalent about my aging process, there is more acceptance of the person that I am. I can now accept the fact that the past is past and while I cannot experience my own death, I know death is inevitable. I still have goals and projects to accomplish. They are not as urgent as they were in the past but without them I would certainly be depressed.

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3

Oldness Demystified

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When I say that I am old, most people say, as if trying to cheer me up in an imaginary illness, "You're not old!" Why do they do that? I feel old. Perhaps I have been old forever, but attaining oldness strikes me as unstartling, unrevealing of ancient mysteries, or unsolving of old puzzles. There aren't any shocks so far. Didn't I know, at the age of 3 and 4 years, when I played with Granddaddy Lieber (my mother's father), then in his ninth decade, that there was something in me that resonated with and prefigured oldness? All the years of living have prepared me for being old; I am not upset or estranged by it. Then, since I feel both old and absorbed in the activities of living, why oh why is the mystique so prevalent about aging being a time of winding down and rehearsing for death?

I sit here in my wondrous library in Louisville, at a word processor. It is in the forenoon, and I felt glad to note just now that my left carpal tunnel syndrome has abated. I try to figure out just how I am aging, what it means to me, and what I might say about it. The chair I sit in at the word processor has a brass plaque hidden on its back, a plaque filled with hyperbolic words to celebrate my retirement from academic child psychiatry at the University of Texas three years ago. It is a token, a sign, of something, I keep thinking. Of what, I haven't decided yet. I do know that many omens point to my oldness. In oldness, as in all the previous stages, the shadow of death is no stranger to me.

An actuarial approach to my life expectancy does not generate any cheer. Although my longevity has already exceeded that of some

of my ancestors and relatives, it has not reached that which others have attained. My father's oldest son, my half-brother, still lives, at nearly 103 years of age; the penultimate one, and my favorite of the whole lot, my sister Edith, died a few weeks ago at 76; and I am soon to be 69 years old. If my Grandpa Adams were alive today he would be 173 years old for he was 52 when my father was born and my father was 52 when I was born. I am glad that my own age of fathering extended from my twenty-fifth through my thirty-fourth years, and that I have been granted some time to be with my grandchildren.

My coping with growing old can be described in polarities and dialectical formulations; for example, as an interplaying of detachment and involvement, conservatism and radicalism, lust intact and sexuality decreasing, values to live by and die by. So that will be my approach.

DETACHMENT AND INVOLVEMENT

I am involved with a lot of living. I have my grandchildren; my wife, a good companion of almost 40 years duration, died earlier this year. I live in the same city where all three of our children have settled down. I am a tip-top handyman in the comfortable house that I occupy. I have an outlet for my gardening urges. Joy is contained in my huge collection of tapes and phonograph discs—mostly baroque, but also art songs and folk songs. In the afternoons, I am seeing some private patients, doing some consultations, helping some young professionals, and giving invited lectures here and there; and, very important for my morale, I am serving three times a year as a visiting professor for a week at a time to the child psychiatry program at the University of Tennessee in Memphis, where I endeavor to entertain and challenge young people in training. I have mornings to write the front-burner book now in progress. In that book I undertake to show that dynamic formulations can be helpful to psychiatry again. Who would deny that I have a lot going? Still, in some ways I am anticipating an end to all of this living.

There is a sort of detachment when one reaches my age that is not easy to explain or justify. Part of it may be from hearing the rustling wings of death's angel at this age. Part of it is a withholding cynicism that says to the other person, "I've previously been through all that and cannot get so excited about it now." Still another part of

this detachment is a bit of plain mellowness that says, "That is important for you, yes, I understand, but it is not a principal agenda item for this current season of mine." And, furthermore, the detachment is a kind of spiritual "decathexis," to use that horrid term coined by the Stracheys for *disinvestment*, or *divestment*, as we commonly say in the U.S.–South African context. It is as though I've withdrawn my interests and energies from some of the deals that are offered me. It partly may be even the Buddhist concept of disentanglement, of loosening attachment, no longer clinging ferociously to things, enjoying a most welcome relief from consuming some of my cherished longings and belongings.

Some of this, for me, unprecedented detachment reflects my wish not to work in structured organizations any longer, even while it pains me that my access to the general psychiatry residents and child psychiatry fellows, whom I love, is impeded. I feel that I have not retired from life, but that I have decidedly retired from working in medical schools and other formal organizations. Leaving academic child psychiatry has its good side because it rids my life of annoying would-be bosses.

It is no departure for me to stress today the anarchistic spirit that I now enjoy and that guided me even when I did work, for the most part effectively, in organized bureaus and groups. My anarchistic delights would not surprise some of my friends who have given me kiss-of-death appellations like "leader of the loyal opposition" in more than one department of psychiatry. I did more than my expected work in the psychiatry departments, but was always critical—of myself, yes, but also unflinchingly critical of them, of their sins and foibles. In my original family of good WASPs I was both a favorite (since I was the last-born of my father's eight offspring) *and* someone to watch carefully lest he turn out to be a genuine black sheep. I have always believed that I could share existence with opponents, that I could be "brutally frank" without damaging my love for them, and that they would always understand that their love and mine were not in question when I was steeped in questions—and questioning of some of the things that they did to themselves and others. That approach did not always work smoothly for me, needless to say, but I have liked its sparkle since I was a child. It is a good way to initiate dialogue if you occasionally run into a person who likes to consider ideas and commitments.

In some ways I see myself as similar to my favorite uncle, a poor farmer who with his good wife's support raised up eight children, a man who could not abide bosses and refrained from bossing others. He might have had a more prosperous life had he been able to work for hire, and to give or take orders as a part of a company, an organization, but some killing of his spirit would have ensued, I feel sure, had he not shunned the market-workplace. In some ways, my uncle Paschal volunteered himself for a life of poverty rather than knuckle under to conformity. The anarchist spirit in our interpersonal and general relationships has stamped my maternal relatives and me prominently. It is my spirit today.

While I am glad to become a freelancer in my senescence, it is the medical graduates who are specializing in psychiatry that I truly miss. Goodness knows, spending between ten and fifteen hours each week for many years, in clinical supervision of these young men and women, is a habit that is hard to drop, wham, overnight. While I am not so pedantic that I must always supervise and teach, and while I do not pine for the role of a teacher, I do ache occasionally for the specific persons whom I was teaching and supervising at the time I chose to retire. Some of my teach-and-supervise drive is taken up by my work at the University of Tennessee. It is so refreshing a delight for me to be there.

At the same time that I am pulling back from the academic medicine workplace, a blessed source of genteel poverty, I conclude as I survey the thirty or so years that I gave to it, I am not pulling away from life or this phase of my life cycle. I feel myself committed afresh on a daily basis, especially to young practitioners—psychiatrists and other mental health workers—and especially to women and children. I do not think that I have done enough yet for mother-only families; I know that those families are brutally neglected in our nation's governmental policies and practices. My commitments are, then, to the soft underbelly underclass of America, a numerous but powerless mass in our country. I feel committed to them and prepared to do all I can on their behalf.

My comrades, my positive reference group, are these poor people, much more than it is psychiatrists or any other professionals. I consider the mind and intellect as precious but I have not found a group of intellectuals who elicited the sociability that I feel for struggling women and their children, from all ethnic derivations.

For Ignazio Silone (1955) the choice of comrades was crucial; he chose the peasants of the Abruzzi, not artists or writers, as his soulmates. I believe he made a wise choice there. Silone felt that it accounted for his not suiciding as, when you think of it, many intellectuals have done: Cesare Pavese, F. O. Mathiessen, Klaus Mann, Ernest Hemingway, Stefan Zweig, Vladimir Mayakowsky, and many others. Silone believed that if his "reference group" had been writers instead of peasants, he could not have survived the despair and absurdity of living during fascism, the Second World War and the Cold War.

In both the Adams and Lieber families, there has been a tradition of social democracy, anticonscription, and pacifism. In becoming older, I think often of that proud tradition but I also fret about how we should have done a better job of conveying our opinions to others.

Warriors surely are not my soulmates, now or in the past. Many psychiatrists of my vintage proudly display their military credentials. But I agree with Dr. Johnson who said that patriotism is the last refuge of scoundrels. My commitment to pacifism, or to militantly assertive nonviolence, is strong and meaningful. I spend a good bit of time contemplating the superiority of institutionalized nonviolence for our world. Some psychiatrists view nonviolence as a utopian ideal. However, I am convinced that more nonviolence, not less, is called for everywhere in the world. Violence is utter dehumanization for both victim and perpetrator, whether in Louisville, Kentucky, or Palestine, Northern Ireland, South Africa, or Bosnia.

In recent years, I seem to have become more utopical than even when I was young. "Utopical" means, to me, an interest in changing social, or societal, customs and institutions, whereas "ethical" means working to change oneself for the better. The two go together, but the utopical deserves special emphasis in our politically conservative day and age.

Without Christianity's reverence for human life and for the individual personality (shared with secular and other religions' humanism), every program to change the world will fail, I submit, as it has always failed in the past. Assuredly, economic socialism and political democracy need to be buttressed by an infusion of *nonviolence as a way of life*, not as a mere tactic, an expedient used by resentful, weak persons who find themselves deprived of guns that they are aching to use. Gandhi and Martin Luther King, now dead of assassins' bullets, are my saints and teachers. Still surviving are the Center for Nonviolence in Atlanta, and other training centers around the country. In

European countries that have a draft, the number of conscientious objectors to military service is burgeoning. Nonviolence is a telling commitment for this old man, binding me to everyone in my species.

RADICALISM AND CONSERVATISM

Getting to be old has clarified some of my general political views and activities, and perhaps not in the way that would be expected from someone like me, who has been called a "respectable radical" for some time. The expectation is that I should become more conservative, or should be a liberal, at best. It is difficult to stay temperate when I say that I am not a liberal, and not a "white liberal" so justly despised by southern African Americans. I am not illiberal, I hope, although I disclaim the label of liberal; it is only that I think radical (going to the roots) is a better way to be. Where I stand today is far from being brand new but instead is quite consonant with my earlier perspectives and projects. In some ways, I feel that I am more radical today than when I was 15 or 20.

I know that many issues call out for conservation: hard work to which one feels "called," democracy in the workplace, social and industrial democracy, civil rights and civil liberties, racial justice, social amenities in public discourse, respect for others, preference for nonviolent negotiation. I am trying to help conserve those values; still, I am not politically conservative.

I remember, during the late 'sixties as I recall, Bill Langford's invective against the Students for a Democratic Society (SDS) who had invaded my alma mater, the Columbia University College of Physicians and Surgeons. It was before I turned 50. Dr. Langford, one of my professors in medical school, and a genial and kind man, thought of the SDS members as scum. I told him I felt strongly identified with the SDS, so that I'd have to take his denunciation of them as an unwelcome denunciation of me too. Langford responded, "But Paul, you have some principles; you stand for something other than action for action's sake." He was right, I do not believe in action for action's sake—the philosophy of the deed—and I doubt that many in SDS were as devoid of principled beliefs as Bill Langford thought. But you can see how some people have befriended me despite my politics. It began in my own family when they passed the test and loved me as I, at age 19 years, became the first white male student at Fisk

University since Reconstruction, and then again in 1945 at age 21 when I traveled with an interracial group all over the state of Kentucky violating jimcrow laws and interviewing anyone who confronted us—police, preachers, movie house operators, bus drivers, and more police and sheriffs. Loads of people in law enforcement.

My heroes have been elderly radicals for a long time, so perhaps I have been elderly longer than I suppose. Let me mention some of them, most of whom I have known personally:

Norman Thomas, the socialist who began as a Presbyterian minister and always cried out in a voice of prophecy against the major American sins of greed, war, group hatred, and prejudice, who visited in our home only a few weeks before his final illness and who was found to be magnificent by our children;

A. J. Muste, the early communist whose *War Is the Enemy* was such an impressive document (Muste, 1942), as was he a moving person to know and talk with when I was a graduate student at Columbia University and found Muste and the Fellowship of Reconciliation so conveniently placed as my neighbors across Broadway;

A. Philip Randolph, the urbane leader of the railway sleeping-car porters, who applied his socialism in the fights of labor and African Americans, marching on Washington in the 'forties and the 'sixties;

Paul Richard, the bearded old French professor at Duke who was a Buddhist and belonged to the Quaker Meeting in Durham, North Carolina, sometimes throwing himself onto the floor in what I thought to be a seizure, but what turned out to be his mystical union;

I. F. Stone, the incorruptible editor and publicist who spoke truth to power, mainly by quoting their own false promises back to the powerful, and who said very simply that he was a "communist anarchist";

Erwin W. Straus, the existentialist-phenomenological psychiatrist whom I met in Lexington in 1945 when, with a group of black and white men, I was traveling across Kentucky to challenge jimcrow laws, and who told us we were "true existentialists" because we had no preset spiel and left it to the immediate moment to prompt what we should say or do;

Roger Baldwin, a conscientious objector in World War I, who gave of his substance in a long life of work through the American Civil Liberties Union;

Jeanette Rankin, antiwar member of Congress, retired in Atlanta, who remained steadfast in her stand, voting against a declaration of

war even after the "sneak," but actually anticipated and welcomed, attack on Pearl Harbor;

Bernard Walton, the Quaker whom I so loved when I met him, an old man, full of vitality and enthusiasm for the small Quaker meetings that were beginning to dot the Southland in the 1960s.

Closer to psychiatry there have been Bernard Glueck, Sr., originator of the first orthopsychiatric team in the Westchester County, New York, Health Department, whom I met in the 1950s when I was a resident in psychiatry in North Carolina; Karl Menninger whose *Love Against Hate* I read in the 1940s and with whom I had a disappointing correspondence in the early 1950s and never met—but who in the 1970s and 1980s never hesitated to align himself with radical caucuses and causes; David Levy, the eclectic psychoanalyst and child psychiatrist who had only child patients in his eighties; Leo Bartemeier, a psychoanalyst and general psychiatrist who was unabashedly Roman Catholic but not stridently so; Bingham Dai, the Chinese American psychoanalyst who is now in his ninety-fourth year and as humanistic and skeptical as ever; Viola Bernard, a world authority on adopted children, fierce fighter for all children, and a social psychiatry pioneer. There are many other elders who have enriched my life: Nicholas Russinovich, my beloved Croatian comrade during my tenure at the University of Louisville, and Lawrence Kubie who undermined most of the psychoanalysts I respected but whom I met in his mellow, advanced years, are only two whom I cannot neglect to cite. I recall with warmth how Kubie, visiting our home in Gainesville, Florida, made a hit with our uninhibited children and knew that, and reciprocated by complimenting them for what many others would have regarded as bad manners. I also admired his not wanting to leave Florida before visiting Miss Lillian Smith, that brave and peaceful warrior against jimcrow and racism, author of *Strange Fruit*, and supporter of the Fellowship of Southern Churchmen, who was dying of cancer in Jacksonville.

My life has been enriched by my knowledge of all these elders. I would wish to emulate their fidelity as well as their substance.

Socialism opened up and regulated by political democracy, and warmly illumined by the ethic of nonviolence and individual liberties is the radicalism to which I cling. It is Quakerism, the Bill of Rights, Gene Debs, Gandhi, and Martin Luther King all wrapped together. I have called myself a libertarian socialist, simply to combine my quasi-anarchical political stand with my collectivist economic position. Such

a libertarian socialism is one that sits well with me as I proceed with a senescent life of commitment and service. For sure, I see no reason for giving it up at a time when eastern Europeans and others are flocking to it.

LUST IMPERATIVE AND SEXUALITY BLANDER

Having been breast-fed until I was about 2 years old, I learned early the joy of receiving pleasure and love out of the body of another. I celebrate that lesson today as I have celebrated it during all my life. There has been some diminution in my sexuality in the past couple of years, but no reduction in desire or delight. Someone said that sexual desire's abatement is helped by old age, but not soon enough! That seems reasonable to me. Maybe Cicero, writing about 50 B.C., had the right idea when he wrote of the reduced hunger for pleasure in old age: "we should be very grateful to old age, which causes us no longer to want what we ought never to have wanted" (50 B.C., a, p. 22).

The older I get, the more certain I feel that bisexuality is our human condition. Freud opposed a movement like gay liberation in his day because he believed that it obscured the homosexuality of all of us. I find that a sensible position today. I have not been called to wave either a heterosexual or homosexual flag, but I concede that for most of my life I have lived in a somewhat androgynously heterosexual life-style that has been gratifying and loving. I have loved family living with my wife and children, but have seen over and over that family living is less advantageous for women than it is for men. Having children to nurture, care for, and learn from, has been a giant reward from family living for both my wife and me.

I cannot believe that the world would be very interested in listening if I ever started divulging the details of my sexual predilections; those could be easily inferred by anyone who knows me, my character; they are ego syntonic. At the same time, I know full well that some bisexuals prefer to live in a strictly homosexual life-style, and they have my unvarnished respect for their nonconformity, authenticity, and happiness. I want everyone to have the right to choose the sexual behavior and life-style that agrees with them.

To me, it is incredible that a woman could be antilesbian, even though I know some who, claiming to be feminists, are; just as it

seems to me foolish for a man to be antihomosexual, but some men are. Restricted to two genders we should at least be able to imagine a physical love for our own as well as for the "other" gender, so that not too much that is human will ever seem alien to us. If I have been inclined toward homophobia at times in my life, I now know those to have been periods in which I was alien to and estranged from a large portion of myself. I am pleased to note that some of my adolescent patients do a better job than most psychiatrists in accepting their bisexuality and androgyny.

VALUES FOR LIVING AND DYING

The curse of the larger world we live in is its nihilistic view that all values, or at least the values of others, are fake. The name of the game is unmasking, living expediently. Again, I know my debt to Ignazio Silone, who wrote in *Bread and Wine* (1936) in the voice of the elderly Don Benedetto: "*Anyone who refuses to live by expediency does not have to espouse a belief in God, for God is in him and he in God.*" That has always reassured me, a rather nontheistic person, but, alas, Silone (1936) revised the only copy I now possess and left out that portion! The older message lingers, however.

Freudians and Marxists share a large part of the blame for the popularity of unmasking as a metarhetorical device, a polemical tactic, with the Freudians attributing "real" reality to the "underlying" id and Marxists to the economic substructure. That leaves nobody in touch with reality except Freudians and Marxists. I find both excessive in their claims. The restoration of civility to both psychoanalysis and Marxism would help the world at large, I suspect.

Values are real, but overlooked in the current upsurge of biological psychiatry. As things that matter most, we ought to find and affirm our values. I am not so confident about religious values, however, since I have seen Christians, Jews, Moslems, Hindus, and Sikhs commit atrocities in the names of their divisive creeds. Protestant Christianity was instilled in my infantile bones, so I still enjoy reading the Bible occasionally, but I am not certain of my Christianity—or Buddhism, for that matter. A universalist, nontheistic, experienced religion will suffice, I think.

Naturally, I expect to die as my ultimate fate. I can feel lighthearted about dying now, because I am in good health; but doubt

gnaws me when I think of my ever becoming incompetent or gravely debilitated before I am let go. I hope that my relatives and friends will be merciful if I should ever reach the point of nonfunctioning as a human person. I should not like to leave a legacy of long vegetation on life-sustaining technology and should prefer to be aided in letting go of life if such a bleak time were to come. A memory of me that is beclouded for my survivors by my being long helpless is not what I'd like to leave.

I want it all but I suppose I might accept less.

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The Aging Psychiatrist

Stuart M. Finch, M.D.

INTRODUCTION

The need for an "introduction" to a chapter of this type deserves some attention as will become clear to the reader as he or she goes on. Initially I had mixed feelings about Dr. Pollock's use of the word *aging* and wondered why he had not utilized such words as *older*, *senior*, or almost any other term which would have been more acceptable to me. His original request was rather vague. He recognized that some of us still see patients while others do not. He fully realized the necessity for disguising patients' individuality but left the author leeway for how much of oneself one wished to reveal. Several questions occurred to me which remain only partially if at all answered. The result will have to depend upon the editor's rejection, revision, or acceptance of what I have written. I have no idea at this point as to other contributors nor how they will go about trying to prepare their own chapters.

I accepted the invitation for several reasons. One is that it gives me an opportunity to think more about this subject that I freely admit I have not emotionally dissected to any great degree. It also raises the problem of how much of myself should be something approaching an autobiography and how much limitation I should put on my own personal background. One thing Dr. Pollock has agreed upon is that if contributions do not contain some element of humor they might as well not be written.

Dr. Finch died on June 23, 1991.

With these questions in mind I had to decide whether to take the approach like the hoop skirt which covers the subject without touching it or the G-String which touches the subject without covering it. I choose more of the former primarily because I think I could do a better job with it. Many writers have undertaken to dissect Freud's personality through his writings, letters, and personal communications. I wonder how thorough this might have been had Freud still been alive today or even written a thorough autobiography.

Initially let me address myself to the question of my own anonymity. When I began my training analysis the old rule of being the blank screen on which the patient wrote was still in vogue. Since being in practice and also in academia, I have discovered this is an impossibility. Most of my patients, perhaps 85 to 90 percent, have been medical people or their families. If they wish to know more about me all they have to do is look me up in *Who's Who* or one of the medical or specialty directories and they can find innumerable facts such as my age, number of children, date of marriage, where I went to school, what I have written, and a number of other things. Whenever I utilize patients or particularly colleagues in this chapter I have sought their consent if disguising their personalities becomes impossible or have deleted them totally.

As the editor has suggested, this contribution does not require research into geriatrics and it is my impression that his primary intent is to elicit the ideas, thoughts, and philosophies about the aging process in those older professionals who either are or have also had experience in treating patients who were growing older. With these thoughts in mind, I will proceed with a random discussion of concepts that have seemed important to me and it is hoped may be useful to those coming along behind me.

WHAT IS AGING?

Theoretically aging indicates the process of growing older. If one takes this concept literally one can easily say the person begins aging from the moment of birth. A 2-year-old is older than a 1-year-old. If, on the other hand, one views aging as the process which ensues following the prime of life when one slowly deteriorates until death, aging is a process which begins at different times in individuals' lives and takes different paths in each of us. As a child psychiatrist and child

analyst it occurs to me, for example, that a youngster with reasonably serious obsessive–compulsive features has already begun to "age." He or she is a little old man or a little old woman by the age of 7 or 8 years. Most of these individuals, when interviewed in adulthood, look back and say they were never children. They always looked, acted, and felt as if they were older than their peers. They tend to resent this missing childhood and in spite of themselves often enforce it upon their own children. By the same token we all know of those individuals who although they advance in years at the same rate as all of us seem perennially "childish." They literally never grow up.

True aging is usually accompanied by gradual physical limitations as well as cognitive ones. The speed with which this happens, and which areas of the body or mind are affected, varies from one person to another. It should be obvious to anyone who has paid attention that two 60-year-old individuals are never alike in their physical, emotional, or mental activities. Time-worn phrases such as, "You certainly look younger than you are," or "You've aged in the last year" are common. From my own experience such casual comments often come as a surprise. For example, such comments as, "Are you retired?" indicate that the other person thinks that if you aren't you probably should be. I myself have learned to fend off such comments with a facetious remark such as, "No I am not retired because I have the scissors but don't have the coupons." In general one may give the impression of being far older than one actually is or conversely give the impression of being young at heart.

ADAPTABILITY AND LEARNING IN THE OLDER YEARS

Each week when I give a seminar at our local Veterans Administration Hospital I pass a poster of a dinosaur with a caption, "Adaptation to change is the secret of survival." Certainly nothing could be closer to the truth.

Teaching is one route which, if done well, requires constant learning. One must try to keep up with one's students or one hopes a bit ahead of them. In medicine, including psychiatry, if one attempted to teach only what was known and taught when one was trained, the results would be boring, outdated, and useless. It is true, as mentioned earlier, that if one can know about the latest advances and contrast them with one's own concept as first learned in training,

it is usually more interesting to the students. If one concentrates too much on "this is the way we used to do it" it is not helpful. I know several professors emeriti who do this to their own detriment. As a teacher, one hopes to be looked up to by students and certainly not dismissed or ignored because of a lack of current knowledge and ideas.

This leads to another point which deserves attention and has even been received somewhat by psychoanalysts. It involves the teacher's idea of helping the students learn, mature, and take their place in their own discipline. These are young men and women who have successfully gone through college, on to medical school, into residency, and perhaps into psychoanalytic training. They are not children and the intuitive teacher learns to respect them as individuals, to give them further knowledge, and to assist them to function as mature men and women. Some older professionals, like some parents, resent their students or their own children striving for more firm identity as well as emancipation. The wise teacher or parent never says, "Do it my way or else," realizing that students will pick up some things from one teacher and other things from another. They get their greatest enjoyment out of seeing former students "doing their thing and doing it well." Some teachers are so rigid and insecure, they fear that some of their pupils will surpass and outdo them and they consciously or unconsciously hold their students back.

One of my greatest pleasures is to look at the number of medical students I have helped encourage into psychiatry and then assisted in completing their training and watched them move on to national recognition in their field. For me to learn of one becoming a chairman of psychiatry, another perhaps a dean, another a chief of child psychiatry, and still another who publishes extensively and is well recognized for their research, is certainly a thrill. To be told these days by such people that they consider me an important person in their success is true gratification.

Those of us who are advanced in years have, during our professional careers, had to continue to adapt to change or fall by the wayside. Examples are numerous. For instance, in child psychiatry we have to deal with the effects of the divorce rate having gone up tremendously. Almost half of today's marriages will end in divorce leaving a greater number of single-parent families. We know this does not promote mental health and is a poor substitute for a successful marriage. We can become discouraged and preoccupied with "the

good old days" or we can make the best of the situation as it presents itself. We can individually get involved with marital counseling, family planning, and other preventive measures, but the tide continues to mount and we must adjust.

Another example is painful to remember but was in vogue quite a number of years ago. It involves putting the psychotic patient into an insulin coma and then giving him electroconvulsive therapy (ECT). The results were disastrous in many cases with fractured vertebrae and other bones and not infrequent permanent brain damage. Insulin has dropped out of the picture and ECT with muscle relaxants, unilateral application, and the attendance of an anesthesiologist is still utilized but sparingly. The advent of psychotropic drugs has led to ECT being usually reserved as a last resort. Familiarity with psychopharmacological advances is therefore essential for today's therapists.

As a broad general rule the neurotic or personality disorder type of physician remains more static and resistant to change. The more mature physician never stops growing and maturing.

PSYCHOANALYSIS AS IT RELATES TO AGING

Psychoanalysis has grown over the years into an international organization. As Freud often said it was a new science and would be subject to change and modification over time. Genius as he was he knew that he and the others were entering uncharted waters and much was yet to be learned. Both theory and practice would change, as they certainly have.

At the time I took my psychoanalytic and child analytic training, the majority of chairs of psychiatry around the country were occupied by psychoanalysts, but this is certainly not true currently.

The rapid growth of biological psychiatry has brought many new discoveries and attracted a good deal of financial support from various sources.

Psychoanalysis is not a hard science and some have even challenged whether it deserves to be considered a science at all. To me it is a valuable part of training and as subject to scrutiny as any other science. There are those who have continued to keep abreast of the advances in psychoanalysis and at the same time tried to keep up with new knowledge in biological psychiatry including endocrinology,

psychopharmacology, and genetics. And alas, there are those who have "frozen" themselves into a never changing psychoanalytic mold.

Psychiatric departments should expose the trainee to all possible approaches available in psychiatry and avoid excessive devotion to one approach to the exclusion of others.

Most mature psychoanalysts, and a training analysis does not guarantee maturity, have continued to grow and absorb new ideas. They certainly do not venerate analysis as a fixed entity but rather see it as a valuable contributing field in psychiatry.

There is the widely circulated story about the man who became preoccupied with attaining and maintaining the best level of physical and emotional health he could arrange. He very carefully studied nutritional books and ate only the proper foods. He kept constant track of his cholesterol level. He, of course, gave up all smoking and alcohol. He avoided all foods which were even hinted at as having potential carcinogenic effects. He arranged his exercise schedule in a rigid fashion. He consulted his physician frequently for the most minor complaints to be certain they were not the forerunners of more serious problems. He studied and practiced how to avoid stress or how to minimize it. In short, he devoted a tremendous amount of time and effort to insure promotion of physical and emotional health as well as longevity. The obvious end to this story is that on his way to the grocery store to pick up a gallon of specially treated water for drinking purposes he was hit and killed by a truck. The moral of this story would seem to me to be that one certainly can go to great lengths to protect one's physical and mental well-being only to have an unfortunate, unpredictable accident or illness. I can recall years ago, at the University of Michigan, annual physical examinations of the medical staff were elective. They were extremely thorough and lasted approximately three days. I myself did not chose to go through this process but did watch quite a number of my colleagues emerge at the end of the three days looking much more fatigued and exhausted than when they began. Unfortunately a few of them were subject to unnecessary surgery and a few others died suddenly soon after of heart attacks or other unpredictable disorders. While I can see the advantage of annual physical examinations, I have seen them carried to extreme. In my case, for example, I have had blood pressure readings for various reasons, and have always been mildly hypotensive. I have no idea what my cholesterol level is and have given little attention to what might make it rise or fall. Not too long ago when I discovered

I could not follow a long drive by someone on a golf course, I decided that it was time for a thorough ophthalmological check. The most embarrassing question the ophthalmologist asked me was the date of my last such check-up. I reluctantly figured out that it had been aproximately twenty-three years previously. The check-up resulted in absolutely no change in my glasses prescription. The answer to my inability to follow a long drive was simply presbyopia. With advancing age one's eye muscles do not react as rapidly to change and therefore make it more difficult to adjust quickly to the flight of a swift, small golfball. Nature seems to have taken care of the situation since I still follow my own shorter drives and leave watching long drives to younger people who do not suffer from presbyopia. It seems to me that during the prime of life most young men pride themselves on muscular prowess but with the advance of age can accept gradual limitations without their own narcissism being too damaged.

With the passing years the analyst often recognizes areas of his own psyche not dealt with during his training analysis and may work out these him- or herself or return for more analysis. It is still wise to have a personal or training analysis available or possible for residents, but this should be elective and certainly not mandatory.

Drs. H. Keith Fischer, Jack Rhoads, and I were the first psychiatric residents at Temple University School of Medicine in Philadelphia. We were similar in age and all of us were just out of the military after World War II. Looking back it would seem that we were particularly fortunate. Resident training at Temple was brand new and Dr. Spurgeon English and his staff were eager to get off to a good start. I am certain that many of his staff, including himself, gave freely of their time with little if any monetary compensation. Most of the staff members were analysts but we had ample exposure to neurology and to work at Philadelphia General Hospital. Our child psychiatry exposure was provided by Dr. Gerald Pearson, also a psychoanalyst. It is interesting that each of us chose to undertake psychoanalytic training but after this each pursued his own special interests. Dr. Fischer remained on the clinical staff at Temple, pursued his interest in psychosomatic medicine and anniversary reactions as well as participating in various scientific community and state organizations. All of this was accompanied by a full-time private practice. Dr. Rhoads soon departed to Duke University where he pursued full-time academic work with an emphasis on analytic training as well as behavior modification. He has only recently retired and is enjoying himself. Mine

was a slightly different path because of my special interest in working with youth. Dr. Pearson went out of his way to help me put together a master's thesis on enuresis. When the Philadelphia Psychoanalytic Association split, each side added training in child analysis. Our group sought the help of Dr. Margaret Mahler and the other group sought Dr. Berta Bornstein both from New York. Eventually we were able to do our own training.

VIGNETTES

During one's life as one thinks back there are usually a few people one remembers as being of particular importance in determining one's future. In the case of my own professional career there were two individuals of particular importance.

The first was O. Spurgeon English, M.D., professor and chairman of psychiatry at Temple University during the years of my training. I first met Dr. English when he was psychiatric consultant to the Eighth Service Command in the army in the early 1940s and I was stationed in Texas. During his relatively brief visit to my base, he made an impression upon me and also casually remarked that he would be beginning psychiatric training of residents at Temple in the not too distant future. He asked me to let him know if I was interested. I had, prior to entry into the service, applied to and been accepted at the Menninger Clinic in Topeka, Kansas, and felt at the termination of my military service I would be in on the ground floor with a few other individuals who had been accepted. After my discharge, I discovered that Menninger's had expanded considerably and that there would be far more residents in training there than I had expected. I called Dr. English in Philadelphia and he reiterated that he would be happy to have me interviewed. This was done and I was accepted as one of the first three psychiatric residents at Temple. I came to know Dr. English well during and after my training. I liked and admired his method of operation and his therapeutic views as well as his emotional maturity and capacity to give freely of his time, attention, and assistance. He always did this in a positive, constructive way. He encouraged me to join his staff after graduation, which I did. A few years later when I received an offer from the University of Michigan, he helped me give it thorough consideration. He is obviously some years

my senior but we have remained friends and our families have remained in contact over the years.

The other individual who sticks out in my mind as having a large influence on my professional career is Raymond W. Waggoner, M.D., professor and chairman of the department of psychiatry at the University of Michigan in Ann Arbor during most of my seventeen years there. I first met Ray at a GAP meeting while I was still on the staff at Temple. He described the recent completion of the Children's Psychiatric Hospital (CPH) in Ann Arbor and his need to find a director for this institution. In spite of the fact that I had had little experience in inpatient child and adolescent work, since it was not available in Philadelphia, he still encouraged me to make a visit to Ann Arbor. After doing so I was awestruck with the enormity of the task he was asking me to undertake in spite of my limited experience. I, of course, did accept the job and the following seventeen years provided me with opportunities rarely available anywhere else in the country to a young child psychiatrist. While Spurge had encouraged me to coauthor a general textbook on psychiatry particularly for medical students, Ray continued to encourage me to publish, and supported all my efforts in this direction. Fortunately Dr. Waggoner appreciated and understood child psychiatry. He gave me a relatively free hand in the running of CPH. He was the type of chairman who always had a definitive reponse to a question or request. If it was in the affirmative you would realize that he would go to any length necessary and within his ability to grant the request. If it was no, you realized that there was nothing he could do about it and the issue was settled. He, like Dr. English, was deeply invested in his staff and their futures. He was always available for consultation. We followed the path we had with the English family and formed excellent relationships with Ray and his family, and these have endured throughout the years.

GRANDPARENTING

There are a number of sign posts in the human lifespan which have significant psychological importance. For example, beginning school, finishing high school, beginning college, marriage, the birth of children, and of course grandparenthood. Each of the events has sufficient significance to be remembered by an individual throughout his or her life.

Grandparenthood, particularly for the first time, usually occurs in somewhat older people although not necessarily aged ones. From a personal standpoint my own grandparents were all deceased prior to my birth. My wife and I have had the pleasure of becoming grandparents of two lovely granddaughters now 7 and 11 years, each a child of our son and our daughter and their spouses. The fact that we wanted and got healthy granddaughters and cared not at all which gender they were surprised our children, each of whom thought that we would be disappointed when both were girls.

Still on a personal note but certainly not an uncommon reaction was that I, as a grandfather, was uncertain of what my role was supposed to be. I felt like sort of an extra wheel which didn't really fit anywhere. Since we don't live geographically close to either family, although we communicate frequently we visit less often. As each youngster developed speech, I became "Grandpa." I was not quite as "aged" at that time but that name required me to try to adjust. When baby-sitting for a few hours on a few days, we have tried to ask for and follow the rules and regulations laid down by the grandchildren's parents. We gave advice only when it was asked.

From my standpoint as the two girls grew we found with age that child rearing was more of a physical and emotional drain where years before it had seemed not so arduous. I think most grandmothers as a group probably handle this better than we grandfathers, but they also find that chasing a 3-year-old is no longer an easy task. The reader should not assume that we do a faultless job. My main points are really two. One, grandparenthood is a milestone in the life of the growing older person and in my daily work I see far too many sad mistakes in this area. It is quite common for the divorced wife or the unmarried mother to return to live with her parents and give them the primary responsibility for raising her child.

Most grandparents assume that they are finished with childrearing, and although they love and accept grandchildren, they do not expect to be their primary caretakers. Parental surrogate roles become confused for the child who is uncertain as to whom they may turn in case of need and who are their primary parenting figures. The single mother is often a working woman or perhaps even disinterested in her child, and turns the entire burden over to the grandparents who are really physically and emotionally unprepared to accept it. The grandchild, while knowing who mother and even father are, remains unclear as to where the major responsibilities for their rearing lie. It

goes without saying that the older the grandparents the more difficult the parental role for their grandchildren becomes.

RELIGION

With some hesitation I have put in this section with full realization that it is a subject that can cause arguments. I do so only because religion obviously occupies an important place in our culture and I don't think it should be ignored in this attempt to look at the aging process both in myself and my past and present patients as well as friends.

With regard to religious affiliation and practice I have some views which I certainly have not kept secret from either my trainees or peers both past and present. It seems to me that what a child learns about religion, especially in the early formative years, lays down an imprint which will remain in some form throughout life. Coming from a relatively nonreligious family, I was not exposed to theological teachings in my early years. I was never given the idea that there was anything wrong with religion but merely that our family was not an actively participating one. It was during my training analysis that it became obvious to my analyst that I knew almost nothing about theology and it was his strong feeling that any practicing analyst should at least have an acquaintance with the broad concepts in theology. Fortunately, my chairman, Dr. English, held a joint appointment in the School of Theology as well as the School of Medicine at Temple University, a Baptist school. He arranged for a joint appointment for me in the School of Theology where I taught for five years. I emerged having learned a considerable amount but not as a candidate for affiliation with an organized church. As an adult learning about religious teachings for the first time, I have seen wars precipitated and fostered by organized religion and it irritated me. I have preferred my own "belief" while retaining the views that others have the right to believe as they wish so long as they do not force their beliefs upon anyone else.

What I am getting at is that in my work in psychiatry and psychoanalysis I respect the patient's religious beliefs and leave them alone unless their neurosis, psychosis, or personality disorder has become intertwined with religion in a crippling fashion and requires further exploration.

I have known gnostics, atheists, and agnostics of equal maturity and see no effect on longevity of devoutness or the lack of it. I do think as one grows older and loses contemporaries one can turn to some sort of belief and can see how that makes the end of life more palatable.

In thinking back over the years, I can recall several adult patients, usually physicians, and often psychiatrists, who made a particular statement to me regarding religion. These were professionals who knew something about me from our associations and were aware that I did not attend church or become involved in such things as seminars on religion and psychiatry. Their comments had one common theme which I have found true, at least in my case. This comment was that if an individual is not indoctrinated in religion as a child it becomes more difficult to get them to embrace organized religion when they reach adult life. These patients felt religion requires a degree of dependency normally more prominent in childhood than in adult life. The youngster is taught to accept the beliefs of their parents' church without question. Coming from adults, the child listens and absorbs what he is taught. If similar material is presented to adults who have not had this indoctrination, they tend to question at least some of it. These adults have grown up to learn to question the reasons behind what they are told and to want proof of some kind. If, for instance, they are presented with a Christian doctrine, they are apt to question a number of things. One would be that if Christianity is the only true religion how does one explain that many other religions with many adherents exist. Or, for example, if Christianity is "the true religion" how come Catholicism and numerous denominations of Protestantism flourish? Or if the individual is raised as I was in a predominantly Mormon community, Jews are considered Gentiles because they do not belong to the Church of the Latter Day Saints. Or why do Catholics believe the Pope has a special route to God while the Mormons believe that the head of their church has this privilege alone?

Certainly, adult converts do exist but this is usually the result of unique experiences or some intrapsychological need for a higher being. This has always been a need of man, and even nonreligious countries such as those that are communistic have failed to stamp it out completely.

MARRIAGE AND AGING

Marriages entered into these days have a different future than those going back forty or fifty years in that about half of the current ones will end in divorce. It is difficult to determine all the factors involved. One can assume, as most psychiatrists do, that we choose our spouse more for unconscious than conscious reasons. If someone is asked why they married the particular person they did, some odd answers are forthcoming such as, "She was cute," "She was fun to be with," "She liked the things I liked." The individual usually has known many others who fit such criteria but were not chosen as a spouse. In dynamic therapy the true unconscious reasons gradually emerge. Most psychiatrists feel that people of approximately equal maturity or immaturity tend to be drawn to each other. The emotional problems of one may be more overt, but more thorough investigation usually reveals about the same degree of inner immaturity. Since no two people are raised in exactly the same environment, marriage requires some adjustment, flexibility, and compromise if it is to succeed. The more mature couple will work these out while the more immature ones tend not to.

The marriages of most aging couples have lasted forty, fifty, or more years. A large percentage of them have remained with the original spouse and for the most part feel that their first choice was correct and they would do it again with the same person. This certainly does not mean that there have not been ups and downs in such marriages but these have been weathered and worked out. They can be said to be capable of a lasting, monogamous, heterosexual relationship. There are many definitions of love but the one I have found most useful I think was mentioned by Ernest Jones, although I cannot find the exact source. It was that love exists when the other person's needs, wants, and satisfactions become at least as important to one as one's own. This means that one spouse cannot do something that would hurt the other because it would also hurt them. It also means that such a thing as infidelity is ruled out because the other person, as well one's self, would be hurt. Love in a mature marriage is not the transient infatuation of adolescence nor the attempt of one or both spouses to expect from the other unrealistic conscious or unconscious deviant needs.

We have long been aware that married people tend to live longer than those not married. The various reasons for this are indistinct but human beings would not seem to be solitary types and to fair better in a marital relationship, especially a good one.

AGING: WISDOM VS. SENILITY

Aging is viewed by some, especially in certain cultures, as being a time when wisdom gained through years of experience is a valuable asset, and younger people view older ones as potential sources of valuable information and knowledge. In other situations and cultures the elderly are viewed as senile and of little help or use to anyone and probably even a burden. At times older people by virtue of their personality put themselves in one role or the other. We all know the occasional professor emeritus who continues to attend departmental faculty meetings, reserves an office in the school, and periodically contributes long, needless, garrulous speeches to the assembled faculty. Here is an individual probably once nationally known in psychiatry and a remarkable contributor. He may have always talked a bit more than many but he was respected and accomplished a great deal. He superficially accepted retirement but could not let go. He continued to be present but lost the respect of his faculty because he had, in truth, become somewhat senile and lost his clarity of thought and good judgment. Worst of all, he did not seem to recognize this, although his wife would appear to.

Contrast to this man (a real person), with another of his age and also a professor emeritus. This one left his faculty office and conducted most of his business from his office at home. He remained active on various local and national committees, but only when asked. He gave freely of his time but again only when it was asked. His thinking remained acute and his wisdom was recognized and sought out (again a real person).

Unfortunately there are those who have considerable wisdom available but the younger generation does not see or recognize it. They are too involved with themselves and their own positions and careers and fail to see a source of potential assistance. The older person put in this position philosophically recognizes what is going on and finds other outlets for their energy and does not try to impress their ideas on the younger group.

AGING AND A SENSE OF HUMOR

The sense of humor begins early in life and if it doesn't start then it is difficult to develop later on. Experience would seem to indicate that those who have it tend to live longer, but more important, they have more fun. This obviously includes the ability to laugh at one's self on occasion since everyone makes mistakes and may look foolish at times. One can either take these situations seriously and become filled with self-recriminations or recognize one's own human frailties and realize that one has plenty of company.

A personal example is that I suffer from what my wife has labeled "geographic dyslexia." I can get lost driving somewhere, especially if it is unfamiliar. This has been with me as long as I can remember. She, however, can find her way around a new town in a matter of a few days. Once I have memorized my route from home to the hospital I had better stick with it, for straying may well lead to complete confusion on my part. Fortunately we both can laugh about this and I can rationalize that I have too much on my mind to mentally organize my surroundings. This put an end to my short career in flying. Most of it went well for me until my instructor would say, "Okay, Let's go home." Since I had no idea where I was nor where "home" was, we both questioned the wisdom of my soloing. Certainly people without a sense of humor can live longer lives but a life that lacks humor seems to be dull and painfully serious no matter how long it lasts.

Obviously life is not all fun and games and serious depressing things do happen at times to everyone. To worry constantly when something bad might happen or to dwell on such events excessively is nonproductive. To grow older and look back on only drudgery, worry, and unhappiness is "bad medicine." To be able to look back at the fun and accomplishments is extremely helpful when one must face growing older.

Child psychiatrists constantly see the roots of pleasurable or unpleasurable life ahead even from infancy. The unplanned, unwanted child has the deck stacked against them. The infant born to a mother who has abused alcohol and drugs during her pregnancy is quite apt to come into the world somewhat damaged. We know that youngsters from families laced with mental illness have more than the usual chance of developing similar problems. Such things do tend to point toward a disturbed and often shorter life span.

THE AGES OF PSYCHIATRISTS AND PATIENTS

There are several different combinations of age of the psychiatrists and that of their patients. Each has its own peculiarities and vicissitudes: (1) the younger psychiatrist and the older patient; (2) the older psychiatrist and the child/teen patient; (3) the older psychiatrist and the older patient; (4) the younger psychiatrist and the younger patient.

One can begin with some common elements which are true in all cases of dynamic therapy and then look briefly at the age differences of therapist and patient as they apply to these general principles. We are referring here primarily to psychoanalysis or dynamically oriented analytic psychotherapy with or without the use of medication. One can begin with a fact that all patients of all ages who have a functional, nonorganic illness share one problem, namely the failure to successfully mature emotionally, appropriate to their chronological age. They have gotten "stuck" or fixated at some earlier level of emotional growth. The nature of the illness will depend upon at what level the main problems have remained unsolved, how severe these problems are, and how the patient is attempting to handle them. For example, some patients internalize these, if old enough, and become neurotic. Others develop character problems and act out their unconscious difficulties. Still others somatize them and develop psychosomatic illnesses. For those who are more seriously ill and become psychotic we are often dealing with genetic or neuropsychological problems also, but they will not be discussed here.

The Younger Psychiatrist and the Older Patient

Most of us can recall the first few years of our practice after finishing training and all of us were usually called upon to evaluate and possibly treat some older patients. The outcome, as in all cases, depends upon the personality of the psychiatrist as well as that of the patient. My own situation at Temple University highlighted some of the most uncommon problems unique to this situation. Although I was a child psychiatrist, I was required to see parents, many of them senior faculty. Some were quite defensive and even mentioned my relative youth and pointedly asked if I had children of my own. Another type, exemplified by a full professor in a surgical specialty, seemed not to

mind the fact that he had obviously been in medicine longer than I had. He and his wife appeared with their youngster and without objection saw a psychiatric social worker while I worked with the youngster. The professor gave little thought to coming in to the general waiting room in his white coat with his name on it. This couple seemed to feel that if the chairman of our department had put me in charge of the child division, he must trust me and so they also could. There was a mutual respect on both sides and as a result things went smoothly. Insecurity on the part of the young psychotherapist can lead to defensiveness. Insecurity in the older patient can also lead to defensiveness as well as a possible inability to accept the younger physician or a series of sarcastic remarks questioning how someone so young could possibly have learned enough or had enough experience to be helpful. If the younger one reacts defensively things can deteriorate. The issue must be faced and worked through before it can succeed. Mutual trust is an essential ingredient in all successful therapy.

Transference and countertransference phenomena should be mentioned. Obviously it is easier and usually quicker for the younger patient to reveal evidences of transference to the older therapist. The countertransference in the inadequately trained younger psychiatrist may be heavily colored by the relationship to his or her own parents in such cases. The bottom line is that transference and countertransference begin unconsciously and one can develop a mother transference to a male or female or to an older or younger therapist. The same lack of logic can prevail in countertransference. The recognition by the therapist and eventually the patient is essential. The conscious awareness of age and sex differences do play a part but the hidden unconscious agenda is crucial. If the therapist personalizes the transference he or she is lost.

One episode remains etched in my memory to this day but has probably been long forgotten by Dr. English who played a role in it. As chairman of our department he called me early one morning at home just before I left for work. It seemed that he had awoken with an upset GI tract and was due shortly to talk to an assembly of all the other chairmen in the medical school and how he saw our department fitting in with needs of the medical school. I was, at the time, a third-year resident but Dr. English assured me that it would be relatively informal, and he knew that I would be able to do it. One of the basic laws in an academic situation is never to refuse a chairman's request.

So I drove to the medical school in a sort of a daze without the foggiest idea of what I should say to such an august group. I frankly do not remember the first ten minutes of my talk but I guess I finally decided I was probably going to get hung so I might as well have my say and get it over with. To the best of memory, I did not wet my pants but I don't know why. The group was kind and receptive and I made it but certainly did not offer a sequel.

One age group of patients poses particular problems for psychiatrists of any age but probably the most for the elderly therapist. Teenagers are neither children nor adults and require special handling. Most of them, having many inward doubts about their own mental health, tend to fear and resent being asked to see a "shrink." This only confirms for them that someone else also thinks they are crazy. The psychiatrist cannot be successful trying to be a buddy to a teenager. If for no other reason than that both doctor and youngster are aware that this is artificial and unproductive. Nor can the therapist be authoritarian, except when it is absolutely essential, or the youngster will rebel. The therapist must guarantee the confidentiality of the relationship unless harm to others or to the young person is involved. Essentially the therapist must convince the teenager that he or she is respected and that confidentiality will be adhered to, and the therapist is not an agent of either parent but rather the youngster's "own doctor."

The age of the adolescent and the sex and age of the therapist often play a bigger role at this time more than at any other time in the life span. The younger the therapist and the older the adolescent the closer they are in age, making a sexual coloration of the therapy a distinct possibility for both. The younger therapist is closer to his or her own teenage years and more up to date on the talk and customs of adolescents. The older therapist, if not up to date, has trouble in communicating with the teenager and more difficulty in temporarily identifying with the adolescent before resuming one's own role. To the older therapist who is "frozen" in the views prevalent during his or her own teenage years there is a gap difficult to bridge. For example, today's questioning about sexual activity is almost routine relatively early in the contacts. These are often answered by the youth without apparent discomfort when years ago such material often required months to unearth.

Something should be said about the older child psychiatrist working with younger prepubescent or even preschool children and their

families. Since all child psychiatrists are also general psychiatrists, the vast majority of them see both children and adults. A steady diet of nothing but children is extremely taxing even for the young therapist and more so for the older one. With a tremendous shortage of child psychiatrists, it has been recommended that in the future child psychiatrists should restrict themselves to seeing only the most ill youngsters, leaving the others to other mental health workers such as psychologists and social workers. Frankly, to have one's day filled with a schedule of drastically sick youngsters with poor prognoses is a bleak picture and I for one doubt that this will ever come to pass.

For the older child psychiatrist the child presents a picture only dimly remembered in one's own childhood. Even though in one's training one learns play therapy, most of us older child psychiatrists have not played childhood games for many years other than when doing play therapy, perhaps since one's own children were growing up or in brief periods with grandchildren. With advancing age it becomes more difficult even in play therapy to join the child on his or her own level of play. We need retain our interest in what the child is trying to tell us in the play. Our enthusiasm may wane when a 9-year-old girl patient challenges us to a contest of rope jumping or a boy wants to put us to the test playing catch. Perhaps the most taxing is the hyperactive 4-year-old with attention deficit disorder who seems bent upon making a shambles of the playroom. His constant activity as he knocks things over or climbs in dangerous places calls for a considerable agility on the part of the therapist. Let's face it, we older child psychiatrists find this tiring and many of us seek refugee in supervising younger trainees.

SOME THINGS THE OLDER PSYCHIATRIST (ESPECIALLY CHILD PSYCHIATRISTS) SHOULD HAVE LEARNED

These are just a few of the things that I feel I have learned through the years along with many of my peers.

1. No two psychiatrists work exactly the same but may get equally good results and therefore respect for one's colleagues should be present unless conditions prove that this is wrong. For example, it is too easy for the biologic psychiatrist to criticize the dynamically

oriented one and vice versa. Each should be acquainted with the other's field and aware of the strengths and weaknesses of both. One should be willing to seek advice from the other and never become narrow minded.

Psychiatrists of any age should hold seeing patients in abeyance whenever there is a crisis or period of turmoil in their own lives. One cannot do a patient justice if a good part of one's mind is preoccupied with one's own problems.

2. For the psychiatrist of any age I would not recommend having pictures of family members in the office. This only adds unnecessary complications particularly to the transference.
3. The child psychiatrist of any age may find several minor suggestions useful.
 a. Do not overstock a playroom, especially with complicated, breakable toys. The fewer times you have to say "no" or "be careful you might break that" the better.
 b. Avoid supplies of candy or other sweets in the playroom. All too frequently this leads to its misuse by the child and does not promote the desired positive therapeutic relationship.
 c. A playroom can easily do without a sink and running water. Sand is fine but does not mix well with water and the plumber's bill gets higher.
 d. Many parents feel a need to "dress up" their child before a session. Good clothes and fingerpaints do not mix well even if one tries to use aprons.
 e. If one uses a portion of one's office as a playroom, the limits must be set ahead of time for the child. Use of a dictaphone or telephone with the button held down may be productive if the child uses them properly to tell stories or hold "imaginary" conversations.
 f. If an outside area is available and perhaps even equipped with swings and slides, children and adolescents often feel more relaxed and talkative than always being in the confines of the office.
 g. Older adolescents often prefer to use the office while most of the younger ones lean toward the playroom. Even teenagers who are a bit older and prefer the office will often welcome the availability of a deck of cards, drawing materials, and checkers all of which soften the more rigid, adult-type interview.

These are just a few of the things I have learned through trial and error.

ACADEMIA AND PRIVATE PRACTICE—FROM MY YEARS OF EXPERIENCE

Over the years I have had the opportunity to be involved in private practice, in full-time academia, and at times some of each. Perhaps my experiences will shed some light on the various advantages and disadvantages of each of these for those who are choosing their future route.

By far the best in my way of thinking is a combination of academia with some private practice but with the accent on the former and the latter as a sort of "safety valve."

Full-time academic medicine can make one a sort of slave to the university. One must follow the rules and regulations laid down by the university, and while it may bring guaranteed income, an office, secretary, and other benefits it leaves little freedom to the physician. It also may give more opportunity for teaching and research as well as a bigger voice in forming the policies of the university. It also brings competition for tenure and promotion which may not always be smooth and congenial. The chronic argument about "publish or perish" not infrequently accentuates the necessity for publications and lessens the value of excellent teaching. This may well put one more at the mercy of administrative officials, which is fine if they understand and support psychiatry, but too many do not. Psychiatric departments are generally not big money makers compared to some of the other departments and this may show up in salary differentiations.

Private practice, especially solo, has its pressures. Being in short supply we are always under pressure to build and yet at the same time control one's practice. When asked by a favorite referring physician to see a patient we hesitate to say no for fear of cutting off a valuable referral source. Seeing just one more patient may well be easy for many nonpsychiatric physicians, but to us it may well mean many hours of treatment and this is not well understood by our medical colleagues. They feel if they would do it for us why can't we immediately do it for them. This can lead to an overloaded practice, long hours, and some resentment on our part. Medical colleagues may

extend professional courtesy to a physician-patient or his or her family and fail to see why we can't always do the same. My partial solution to this I found years ago with our pediatrician. In the beginning I explained my situation to him and said that I would be happy to evaluate him or any member of his family without charge but would have to begin to charge if longer therapy were involved. I felt it was better to get him to charge me for seeing my children and felt more comfortable about calling him when I saw the need. This worked well and saved both of us from buying expensive, not needed, gifts for Christmas.

Psychiatrists in private practice have no one between them and the patients, while full-time academic psychiatrists have "mother university" between them and the patients. I have found this tends to dilute the therapeutic relationship.

One primary drawback in the academic/part-time private practice situation is that unless it has fairly enforceable rules, some faculty allow their private practice to grow at the expense of teaching and research. The regulation should include the percentage of time allotted to the university and the percentage available to private practice. It is my feeling that the physicians in this position should see their private patients in their hospital office rather than their own private office. This allows them to be available for consultation more easily. Many universities are finding they cannot compete monetarily with the private sector and are offering to faculty some limited opportunity for a given percentage of private patients. They thus can retain good teachers and researchers and not lose them to the more lucrative private practice sector. Each young psychiatrist and child psychiatrist must realize that we are in the shortest supply of any medical speciality, there are many avenues to chose from, and one should evaluate one's own interest and needs.

5

Senior Patients, Senior Psychiatrists, and Senior Politicians

C. Knight Aldrich, M.D.

This chapter is divided into two parts: Part I concerns memory loss in the elderly—particularly benign senescent forgetfulness—and its effects on people in various occupations from politicians to psychotherapists. Part II uses a case history to illustrate psychotherapy with elderly patients.

PART I: MEMORY

I first heard about memory loss in the elderly when I was in medical school back in the late 1930s. Unfortunately, the professor who gave us our first clinical lectures in psychiatry disliked patients almost as much as he disliked students. His teaching, however, was worth listening to in spite of his irritating ways. He had a sense for the dramatic and, although he outrageously bullied the demonstration patients he brought in from a state hospital, he got his points across. In his senility lecture he embarrassed four or five poor old souls who couldn't remember where or who they were—or maybe they were too far along to be embarrassed, although we were not—by asking each of them orientation questions. He punctuated these questions with comments to us such as, "See, see? He doesn't know where he is or when it is or even who he is." Then, as the patients shuffled off, he turned to us with a complacent grin and said, "Pay close attention to these vegetables. Every one of you will end up like them if you don't die of

something else first. The brains of all of us start deteriorating from the day we're born, and go on deteriorating until we become like the patients you've seen today. We're lucky that most of us will die of tuberculosis or pneumonia or heart attacks long before we get to this point."

He went on to tell us about Alzheimer's disease and to show us a patient or two. In those days, the term *Alzheimer's disease* was applied to an early form of senile dementia, also known as *presenile dementia* (Alzheimer, 1907). Although the characteristic pathology of Alzheimer's had been reported, the clinical condition was thought to differ from senile dementia only in its occurrence at the younger end of the curve. At the other end of the curve were people like Oliver Wendell Holmes, but presumably even he would have become senile if he had lived to be 120 or so.

For many years medicine continued to subscribe to Alzheimer's views. Recently, however, along with new concerns about geriatric psychiatry, the concept of Alzheimer's disease has been extended to include most of what we used to call senile dementia. Meanwhile, new interest in searching for the causes of Alzheimer's disease ranges from genetics to aluminum in the hope of finding something that's reversible.

At the same time activists on behalf of old people have been trying to convince us that unless we have Alzheimer's, we are perfectly all right mentally—well, maybe a little slow on the uptake, but for all intents and purposes as good as we ever were. An example of this kind of propaganda is a letter by T. Franklin Williams, who says that there is:

> [E]xtensive, thoroughly documented evidence in the past 10 to 15 years that there is no such thing as "senility" or inevitable decline in mental function in old age. Rather we know now that most people suffer no mental deterioration because of age. When significant mental or memory changes occur, they are caused by diseases . . . [*Washington Post*, June 17, 1989].

Mr. Williams represents a large faction which believes and wants us to believe that while our eyes, ears, teeth, hearts, guts, prostates, and everything else do not work as well as they used to, our brains are immune from any adverse effects of aging unless we have Alzheimer's disease or strokes.

Presumably, this unlikely theory will reassure us old codgers—just stay healthy, and our memories will be as good as ever—but the fact of the matter is that it does the opposite. In the first place, we don't know what to do to keep healthy and avoid Alzheimer's; in the second place, regardless of what Mr. Williams and his cohorts say, we do know that our recent memory is not as good as ever. Practically all of the people I know in my age group complain that they forget keys, lose names of friends, or can't remember whether they've taken their pills. True, they've forgotten keys, names, and pills all their lives, but they forget more of them than they used to, and if they believe that their diminishing memory means that Alzheimer's is about to descend upon them, they're hardly reassured.

They're also scared by seeing so many friends who *do* have Alzheimer's. As medicine has conquered tuberculosis and made inroads on pneumonia and heart disease and other killers of youth and middle age, more and more of us survivors actually do develop Alzheimer's and hang on to show the deterioration that my professor liked to dramatize. So it is all around us, and when we recognize that our recent memory isn't what it used to be it can't help but be frightening as well as depressing.

Meanwhile, we do our best to compensate: we use our notebooks a lot more, we feel the toothbrush once in a while to make sure we haven't already brushed our teeth, and we try to comfort ourselves by saying, "I can't remember right now, but it will come to me in the middle of the night." This memory loss is a nuisance, and it doesn't get any better, but at least it gets worse slowly, and for most of us it will be a long, long time before we will turn into disoriented senile dementias.

But if this pesky memory loss isn't Alzheimer's, what is it? Is it a separate condition, or is it a way station en route to Alzheimer's? Kral (1978) thinks it is separate, calls it benign senescent forgetfulness (BSF), and observes that it affects the majority of people my age. As its name indicates, its course is benign, it is senescent and not senile, but it is definitely forgetfulness. Kral claims that there's a qualitative difference between BSF and Alzheimer's—that they are different kinds of memory loss. Brayne and Calloway (1988), however, aren't so sure; they make a reasonably convincing case for a continuum from normal through mild forms of forgetfulness to Alzheimer's.

The Harvard studies of elderly folks in South Boston (Evans and colleagues, 1989) may be saying the same thing. They identified 3

percent of people 65 to 74 as having Alzheimer's, 19 percent of those between 75 and 84, and 47 percent of those over 85. There weren't enough subjects over 95 to give figures for, but extrapolation of their curve suggests that the disease is so ubiquitous that it must be considered a part of aging, like gray hair. One may be prematurely gray or, perhaps like Ronald Reagan, belatedly gray, but if you live long enough, gray hair will catch up with you. At least in South Boston, the logic seems to apply to Alzheimer's essentially as my old professor told us—plus ça change, plus c'est la même chose. Kral (1978) also believes that we BSFers have insight—we know we're slipping—while Alzheimer's victims don't recognize their limitations, but that, too, can be related to degree rather than to kind. As long as it is not clear whether the difference between the two is quantitative or qualitative, however, I prefer to believe that they are separate conditions.

Selective Early Retirement

As I said, we compensate for defects in recent memory in a lot of ways, but these ways take time. Most of us have enough time to compensate, but not all of us. Recent memory loss is bad news for anyone who must process a lot of new data and then remember it all quickly and accurately. Flying supersonic military aircraft—or, for that matter, flying any aircraft—is not for us. How about driving a car? That brings it close to home; I want to keep my driver's license as long as I can, but I am not sure how long I'll be safe on the road. So far, I've been able to convince myself (I don't have to convince the Department of Motor Vehicles, but maybe I should) that all my years of experience counterbalance my slower response time and my forgetfulness.

So, I'm for early retirement for aircraft pilots, and maybe for motor car drivers. For other professions, it depends: a solicitor, for instance, in the British sense of the word, could have a reasonable degree of recent memory loss and get along all right, while a barrister, who has to plead cases in court, would have trouble.

A Supreme Court justice is more like a solicitor, with plenty of time to arrive at decisions, although some of the nine old men in the Roosevelt era were a bit beyond the point of effective function. Anecdotes about memory loss in the Court are more frequent than scientific studies; Oliver Wendell Holmes tells a story about Supreme Court Justice Robert Grier, whose memory loss had progressed to the

stage of incompetence by 1869, when he was 76. He still held his seat, however, until a major case came up, with the rest of the court split four to four. The other justices decided that they could not let Justice Grier make this crucial decision, so a few of them, led by the then relatively youthful Justice Stephen Field, called on Justice Grier to ask him to retire.

Justice Grier retired, and what happened to the case is not clear, but it is clear what happened to Justice Field over the next thirty years—his memory went the way of Justice Grier's and in due course a delegation was assigned to break the bad news to him. The delegation leader began by trying to soften the blow by asking Justice Field if he remembered his participation in Justice Grier's retirement.

"Indeed I do," said Justice Field, pulling himself together, "and a dirtier day's work I never did in all my life!" According to the story, this led to the retreat of the delegation in some confusion.

Although both Justice Grier and Justice Field outlasted their competence, the Court's function is protected by its size: nine Justices provide safety in numbers and all of them are not likely to deteriorate simultaneously. In the same way, legislatures can adapt to members with BSF and even to an occasional member with Alzheimer's.

The executive branch, however, does not have that safeguard at the top—there is only one President. When communication was by pony express, the President had plenty of time to remember and to get consultation, but these days, with the "football" in his hands, he may almost instantaneously have to assimilate new information, sift it out, and act on it, with full awareness of all the implications of whatever he does. He needs a relatively young memory for that, and that's why I am for a Constitutional top age limit of 70 for presidents to balance the lower limit of 35 (Aldrich, 1988). FDR was for a top limit of 70 for the Supreme Court but not, so far as I know, for presidents. I'm just the opposite: I would not put an age limit on the justices, or on members of Congress, but I want to reduce the risk of having a forgetful president. I must admit, however, that my suggestion has not met with the enthusiastic response that it deserves.

To return to more mundane matters, how does recent memory loss affect me as a psychiatrist? More specifically, as a psychotherapist; for many reasons, I don't do hospital or emergency work any more, which is just as well, since they both require excellent recent memory. I still carry out psychotherapy, however, and as the years have passed, I've been able to convince myself that remembering everything every

patient tells me is not as important as I used to think it was. As long as I'm open about it, and don't try to fake it, I'm all right—or so it seems. (Denial may be helping here, too; I don't want to give up psychotherapy any more than I want to give up driving a car. Rationalization is also comforting: I tell myself that psychotherapy keeps me from stagnating, but of course that's not a justification for continuing to carry it on if it keeps patients from seeing someone who is more competent.)

My patients remind me if I can't remember whether one of them has three or four children, or two sisters and a brother or one sister and two brothers. When I start forgetting crucial events in their lives like bereavements, I'll know, I hope, that it's time to close up shop.

Meanwhile, I reassure myself that experience balances out the effects of aging, just as with Supreme Court justices, senators, and congressmen. It's not quite the same, however, since all of them work in a group, so if Senator Trumpet can't remember the point of a bill, Senator Trombone can help him out, and vice versa. I'm all alone, more like the president than the Supreme Court justice, and I have to make decisions on evidence that only I have been exposed to. So I have to make more notes than I used to and give myself more time between patients to think about what's likely to come up in the next hour. Of course, I'm more interested in my patients than in whether I've brushed my teeth, so I have less need to test the psychiatric toothbrush, but memory limitations are having their effect.

So far, I haven't gone to sleep during psychotherapy, although occasionally I've had to work hard at keeping awake. While I also haven't yet succumbed to taking a regular daily nap, I'm beginning to schedule patients to avoid the predictable diurnal dips in alertness which get more pronounced as time goes on. Closing up the office is getting to be a more attractive prospect than it used to be; as of today, 1993, I think that 1996 should be about right, if I can hack it that long.

It's also three years off, so I don't have to deal with it now. As it gets closer will I, like Justice Field, deny how far memory loss and the other failings of aging have progressed? The mechanism of denial is so ubiquitous among those who ought to retire that every one was amazed not long ago when the best third baseman baseball ever produced decided all by himself, apparently without outside pressure, that it was time to call it quits.

Everyone was amazed, not only because he did *not* deny that he was slipping, but also because they *were* denying that he was slipping. In the same way, denial protects aged doctors as well as athletes from recognizing what's happening to them. When old Doc starts making mistakes in his surgery or his prescriptions, he denies their significance, and he is protected for a while by all those around him who need to deny that the father figure is vulnerable. But as the evidence piles up, their denial gradually breaks down, until someone finally gets up the courage to tell the Emperor that he has no clothes. The doctor is distressed, but not for long; his defective recent memory helps denial take care of that, so he simply forgets what he's heard. Finally, the damage he is doing to his patients becomes so evident to his colleagues that a delegation, as in the Supreme Court analogy, is told off to do the dirty work.

PART II: PSYCHOTHERAPY

The psychiatrist in office practice is more protected; he has no one but his patients to blow the whistle on him when he becomes incompetent. But most psychotherapy patients have even more of a need to protect their therapists than other patients have; as for the ones who don't have that need, their criticisms of their therapists can always be attributed to negative transference. Our psychotherapeutic mistakes, if any, are seldom evident to our colleagues, so we are spared the delegation's visit. It therefore can be easier, perhaps too easy, for us to keep going past the time when we ought to quit.

There's another reason for worrying about memory loss. We not only need to remember what the patient says, but we need to be able to formulate the patient's problems according to that person's individual experience and feelings. That seems obvious, but too often psychotherapists force patients into preconceived stereotyped patterns with which they are familiar. Recent memory loss makes stereotyping easier; as with our increasing trouble processing new information, we rely more on past concepts—better remembered if not always relevant.

We tend to recognize this problem of rigidity more easily in patients than in ourselves. Thus, when I was a candidate at a psychoanalytic institute with a high titre of superannuated faculty members, I

was told unequivocally that older people were too rigid for psychoanalytic treatment. For a long time I not only accepted this psychoanalytic tradition, but, as was the custom in those days, applied it without much qualification to any psychotherapy.

In recent years doubts have been raised about the applicability of this and other psychoanalytic traditions to psychotherapy. It took a patient to convince me that the longer problem-solving experience of the elderly can often compensate for increased rigidity in making adaptations. The patient was a 78-year-old retired schoolteacher I'll call Lois Calder.

She had been referred to me for assessment of possible dementia, and indeed when I first saw her, she seemed to have lost a lot of ground. She also appeared depressed, however, and I wasn't sure how much of her depression was due to dementia and how much of her recent memory deficit was due to depression. Since I'm sure that at least one of the contributors to this book will be discussing this important differential diagnosis, suffice it to say here that I soon concluded that depression was the chief contributor to Lois' distress. I was involved in a study of aged people at the time, and so I set up a series of treatment sessions with her, more, I must admit, to learn about aging than with any psychotherapeutic ambitions.

Lois was a tall, gawky, homely woman from the Midwest. Her features were large and "craggy," her hands and feet were oversize, and her arms and legs well muscled. She had never had a serious boyfriend and at an early age she had settled for being an "old maid schoolteacher."

She apparently had been an excellent teacher, committed to her students but at the same time able to let go of them as they matured. Her remote, workaholic father died when she was in teachers' college, and her traditional family assumed that, as the only unmarried daughter, she would live with and care for her mother. Her mother, pretty and feminine, and accustomed to being cared for like a queen, made no secret of her disappointment with her daughter's failure to attract a husband, but was perfectly agreeable to Lois doing the housework as well as her teaching job.

When Miss Calder was in her late forties, her mother died. She said that at first she felt guilty at not having done more to keep her mother alive, but soon recognized that her guilt was unrealistic, due primarily to her sense of relief at being out from under her mother's domination. She thought it had been sad for both of them that her

mother had been so preoccupied with external appearance, but concluded that her mother was a victim of her own upbringing.

After her mother's death, Lois went through an appropriate period of grieving, punctuated by a row with her siblings over the disposition of the family home. Lois won the battle, and asked Alice, another teacher, to move in with her. Alice, a childless widow, was pretty and petite, but somewhat limited in her activity by rheumatoid arthritis. Lois, therefore, did most of the housework, and soon after Alice retired on disability.

Lois eventually had to retire, and at first wondered how she would cope. She had, however, developed an interest in gardening, to which she now could give more time. She tried tutoring for a while at a children's orthopedic hospital, but soon decided that she had done as much teaching as she wanted to, and Alice's slowly progressive disability required increasing amounts of her time. Eventually, Alice, who was deteriorating intellectually as well as physically, became too much for Lois, and had to go to a nursing home. Lois recognized that it was "like putting my mother away," and that it stirred up some of her residual feelings about her mother.

This time, however, Lois seemed unable to cope with the loss, and it was her continuing depression that brought her to me. Her inability to cope puzzled me, since Lois had done so well with previous losses and seemed so insightful about this one, until, during about the eighth interview, she volunteered that there was something else bothering her that she hadn't told me about. What troubled her were her sexual feelings for Alice, which she had not become aware of until shortly after her retirement, and which were particularly troublesome when she was bathing Alice. She acknowledged that were it not for these feelings she could have managed to go on caring for Alice. Alice's move to the nursing home was precipitated, therefore, by Lois' inability to continue to tolerate the sexual feelings and her consequent feelings of shame. Homosexuality was and always had been completely foreign to Lois and to her family; she was sure that Alice had no idea about her feelings, and would have ended the relationship if she had any suspicion.

My first reaction was embarrassment that I had not taken a sexual history because of Lois' age. My next reaction was perplexity—what do I do with this information? Maybe the two were really one: I didn't get the history because I didn't know what I would do with it. At least I was glad that I hadn't cut off her story and loaded her up with

antidepressants at the beginning, as so often happens with elderly patients.

But what to do? The long, arduous process of searching for psychological contributing factors in her early family relationships seemed unlikely to pay off; bringing about a major switch in her attitudes toward homosexuality seemed a prohibitively long shot; and I didn't think she would buy any type of direct reassurance that I could dream up.

Although by now I realized that most of her memory loss had been due to depression, and that with time or therapy both the depression and the memory loss had shown signs of improvement, I still sold her flexibility short. Fortunately, however, I didn't know what else to do, so I gave her an opportunity to prove me wrong. I asked her how she pictured herself in her childhood wishes and daydreams, and, of course, she described someone like her mother and like Alice—pretty, petite, and feminine. She then spontaneously went on to wonder whether her feelings about Alice could have symbolized her love of the person she wished she had been.

This hypothesis intrigued her, and she continued with a somewhat intellectualized discussion of narcissism and the Narcissus myth. Together we considered whether Narcissus was really in love with himself or with someone like himself, and she pointed out somewhat ruefully that Narcissus didn't have her problem—he was content, perhaps too content, with the way he looked. By this time it seemed evident that she was reaching for the mechanisms—regression, rationalization, intellectualization—which she had used before to cope with losses. She seemed less depressed and more animated as the session ended.

Somewhat to my surprise, her improvement continued. In subsequent sessions she avoided talking about her sexual feelings, saying that she had found my explanation (which was really hers) quite acceptable and very reassuring. She talked a good deal about Alice's continuing downhill course and imminent death; she visited Alice in the nursing home from time to time, but felt that she had already said farewell, and she was able to tolerate Alice's death a few weeks later without undue distress.

After that, we terminated our formal sessions, but I kept in touch with her. Three or four years later, she fractured her hip and could no longer live independently. I helped her make the transition to a nursing home, and as I saw her settled in, she said to me, reminding

me of Jerry Frank's generalization about psychotherapy (1975), "You're always there to keep up my morale when something happens." I didn't think she was still depressed, but I couldn't be sure. She had covered her feelings before, and might well have wanted me to believe that I had "cured" her. To some extent she saw me as one of her students whom she had launched and then let go, but still wanted to be successful. Three months after entering the nursing home, she died.

At the time, I was working on a study of elderly people who were being transferred from one nursing home to another. I had known that death often followed institutionalization of the elderly, but I was somewhat skeptical of the conventional wisdom that these people died only because they were at death's door anyway. I welcomed the chance, therefore, to study the problem when an old-fashioned nursing home with the equally old-fashioned name of "The Chicago Home for the Incurables" had to go out of business. My colleague and I found that the first-year death rate of these transferred people, relocated because of administrative rather than medical reasons, was three times the expected rate, and that most of the increase was clustered within the first three months. We also found that the increased mortality took place among those who were demented, who denied the imminent move, or who became depressed at the prospect. Most of those who were philosophical, properly apprehensive, or angry were survivors (Aldrich and Mendkoff, 1963).

Lois had seemed philosophical about the necessity to go to the nursing home, and of course there's no law that says that those who are philosophical won't die soon after the move. If she were depressed at the time she entered the home, at least she was not as depressed as she had been at the time I first saw her. And indeed, I *had* been her student. She taught me an important lesson, not to assume that because a patient is elderly and has some loss of recent memory, psychotherapy—at least, supportive psychotherapy—is not indicated.

There is both good news and bad news in this chapter—rather, there is reason for both optimism and pessimism. On the pessimistic side, evidence seems to be accumulating that recent memory loss is an integral part of the aging process, and that it eventually leads to what is now called Alzheimer's disease. On the optimistic side, the progression from early recent memory loss to Alzheimer's is usually very slow.

Also on the optimistic side—although hardly news, since we've known it for some time—is that as Lois' case shows, the elderly may be a lot more adaptable than they appear, and may be able in psychotherapy to reach back and reuse patterns of adjustment which have served them well in the past.

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6

Reflections on Aging

Robert Lippert, M.D.

The contemplation of one's aging processes and one's mortality is attended by anxiety, which is either felt, denied, or transformed. I am no exception to this, and as a physician and psychoanalyst, my awareness is heightened by my professional training and observations of the life processes in myself, in colleagues, patients, friends, and members of my own family.

Man is probably the only species with an awareness of the tenuousness of its sojourn on Earth, and this awareness comes into focus at an early age. My first conscious awareness came when I was 4 or 5, when my maternal grandfather—a beloved figure to me in my childhood—died during the dreaded influenza epidemic of 1919. This patriarch, a gentle man who loved his family, took ill one night in March 1919, and, within a few days, died. As a medical student I would remember the events of 1919 and the irony of his death at age 52, at the dawn of a decade that would lead to the discovery of antibiotics and influenza vaccines. These impressions sensitized me to the precious quality of our lives—the irretrievable aspect of even a passing moment and the necessity of spending time judiciously.

In Freud's essay (1916) "On Transience," the evanescence of life is cited as a reason to raise the value of its enjoyment, rather than to despair its passing and forgo this pleasure. Quoting from Freud, "A flower that blossoms only for a single night does not seem to us on that account less lovely. . . . Nor can I understand any better why the

beauty and perfection of a work of art or of an intellectual achievement should lose its worth because of its temporal limitation" (1916, p. 306).

An article written some years ago in a learned journal, after many pages, came to the conclusion that life in itself had no purpose, adding that, to many, this may come as a frightening shock, a deflating insight. The author indicated that one could view life as a tabula rasa—with its purpose to be determined in large measure by the purposes we assign to it. The use to which we put this tabula rasa can be enriched by greater self-awareness and insight. To psychoanalysis I owe a debt for opening such doors of awareness. The failure to resolve deep feelings of inferiority and worthlessness or irrational guilt may launch one on an insatiable lifelong quest for recognition, squandering years in an effort to satisfy some unthinking parent or parent surrogate.

I once treated a middle-aged man, who after years of striving, exclaimed that his mother could never be satisfied with his efforts; that no matter what he did, she never felt it was "right." And he echoed similar feelings about his former wife, who divorced him because he finally rebelled against her expectations and (to him) unreasonable demands. Before coming to see me, he had been depressed for years, and felt that it was useless to go on. It is interesting to note that this patient sought out a career where he had very little positive feedback, and although he received generous material rewards for his efforts, he felt that his employer was too distant and too insensitive to his efforts and achievements, regardless of how productive he was (much like his mother). He had a gloomy outlook for his later years despite the fact that he was extremely well liked and had a superior and creative intellect.

The pathways of developmental processes—and the patterns of aging—vary from one person to another. The helplessness of the infant, whose principal goal is survival, and who is very dependent on maternal nurturing, is at one end of the spectrum. Ideally, the child's dependence is accepted, and with adequate physical and emotional support and sustenance, the helplessness gradually gives way to attempts to active mastery of the environment. With development of the neuromuscular apparatus the baby acquires techniques of mastery and eventually becomes an individual who is potentially autonomous and self-initiating.

With early childhood, the baby is developmentally on the upgrade: physical, intellectual, and integrative capacities are increasing along with perceptive and communicative skills. Adaptation to the environment is being perfected and refined, and the child's socialization and interactions with others are of increasing complexity.

As the child approaches puberty and adolescence, the life experiences lead to increased sexual differentiation and awareness, and further unfolding of psychosocial experiences and involvements; the young male thrives under the aegis of constructive role models, and the young female similarly has a need for constructive parental role models as she approaches womanhood. A sense of hopeful optimism accompanies the developing healthy young adult.

Along with the complex developmental processes there is a gradual shaping of character. This may be viewed as the sum total of the ways in which the individual reacts to and copes with the problems of life. The character of the individual also encompasses his or her habitual outlook on life, their self-view, and their moral and ethical principles. Gitelson (1973) states this succinctly: "Character . . . is the overall adaptive pattern of the person" (p. 118). It is partly constitutional, but the person's life experiences and their emotional environment is far more decisive in shaping their character. The character of parents or parent surrogates beginning in early life is crucial: attitudes toward security or insecurity, assertiveness or submission, optimism or pessimism, trust or mistrust of others, receptivity to new experiences or ideas, curiosity, and emotional expressiveness or reticence are some of the character traits learned early in life. These in turn have much influence on how the individual deals with the phenomena of aging. The pattern of the aging process in a given individual will be greatly influenced by the patterns of his or her character as a mature adult.

In reflecting upon my own developmental experiences, I am reminded of the influence of several relatives: a loving but overprotective mother against whom rebellion was inevitable; she and her well-meaning sisters (my aunts) would swoop down on me at the beach when we were on a summer vacation and indoctrinate me with the extreme dangers of drowning! The result of this: I did not learn to swim until I was nearly 50, and at that time I taught myself to master the art.

Countering these well-meaning persons, my father and a maternal uncle were quite permissive, and encouraged an open exploratory attitude toward life and this has served me in good stead to this

day. My father was an easy-going, sensitive man with an attitude of indignation against social injustice; he enjoyed literature and music and, when I was only 5, played classical and operatic phonograph recordings with the hope that I would develop an appreciation of music (I did). He lived modestly and reasonably and resented the pressures of more affluent relatives to become an entrepreneur. This had a beneficial influence on me and, since my father's death at age 90, I see how wise he was not to be consumed by the quest for power or great wealth.

My maternal uncle, in contrast to my father, was a hard-working professional, with a keen eye on planning a prudent economic future. From him I learned how to heed sound economic advice, so that my professional activities would be freed from undue monetary concerns and pressures. He planned wisely for economic independence, but regretted retiring at age 80, and felt that his retirement had a detrimental effect on his life (he is 95 at this writing).

Recollections from childhood are replete with a rich collection of relatives, friends, and peers. I was lucky in having two sets of grandparents, and as the oldest grandson enjoyed a preferential status in our extended family. This had its advantages and disadvantages. Discipline was minimal, and the indulgence of well-meaning parents and relatives hindered my socialization. Some of my youthful grandiosity had to be tamed and brought into harmony with the demands of reality. An early birthday party is cited as illustrative of this overindulgence: my mother related how I wanted the whole chocolate birthday cake, and presumably she was almost willing to let me have it! My more realistic maternal grandmother set definite limits to such excesses in a firm but gentle and loving way. She afforded me hours of pleasure in her kitchen, where in her presence I witnessed the secrets of her culinary creations, while listening with fascination to her rich accounts of romanticized family history. She related the heroic resourcefulness of a great grandfather who was clever enough to survive the threats of the czarist military, and who was something of a local hero in the town of Friederichstadt, Latvia. My maternal grandfather was a brewer and distiller and his supplying the occupying Russian troop commander with liquor from his distillery probably was an important element in the family's survival. In 1905, sensing an uncertain future in Latvia, he emigrated to America, taking along his oldest daughter (my mother) and a year later he sent for the remainder of his family, and a large portion of his worldly

goods—books, furniture, and a gleaming samovar which I later inherited. These incidents would be related as we sat around a huge dining table during many family gatherings. The relating of the sagas on the high Jewish holidays contributed much to my feelings of soundness and belonging, and I felt very fortunate to be a member of this large, solid family.

I gradually learned to tame my impulsivity and rebelliousness, though I paid a price for the earlier overpermissiveness of my family. Adolescence had its storms, but I survived without serious damage. My understanding and benevolent maternal uncle facilitated my introduction to the pleasures of sex by adopting a tolerant attitude to my confession to him of my liaison (at 17) with an older woman (!) of 27. Instead of being critical, he reviewed the state of my biological knowledge, remarking that I was fortunate to be seduced by a willing, lonely young woman who was so well informed.

A benevolently disposed biology teacher channeled much of my energy and curiosity into science, and a high school English teacher encouraged me to write and to enjoy literature. By the time I entered college, I was interested in the field of medicine. I made a conscious decision to devote all of my energies to my studies, and the four years of medicine were shared with my first wife, who was a patient, supportive, and wise woman. Internship was chosen in New York. I wanted to leave the Midwest and broaden my personal and professional horizons.

While an intern, in 1939, I heard of the death of Sigmund Freud. I had previously read his *Introductory Lectures* (1916–1917) and *The Psychopathology of Everyday Life* (1901), and was fascinated. At King's County Hospital (Brooklyn, New York) there was a stimulating group of New Yorkers, including Jack Arlow and Edwin Kasin. We took our meals together in the Staff House and my curiosity regarding psychoanalysis was increased by our many discussions. A neurology resident demonstrated the removal of hysterical symptoms with the aid of sodium pentothal, and demonstrated his use of hypnosis in an amnesic patient.

My wife joined me during the second year of my internship. The appointment was exciting and afforded me a broad exposure to the various medical and surgical specialties and to psychiatry. My wife worked as an office assistant to one of our attending staff while pregnant with our first child, who was born just before I finished my internship on May 29, 1941.

We returned for a short time to the Midwest on July 1, 1941. I had an interim job on the staff of the Manteno State Hospital, where I was assigned to an unbelievable caseload consisting of four closed wards of acutely and chronically disturbed patients. I made the acquaintance of Dr. Walter Kirschbaum, a German refugee and neuropathologist, who had worked with Wagner-Jauregg, and he was delighted to teach me whatever he could of neuroanatomy and neuropathology. Next I went to the Veterans Administration Neuropsychiatric Hospital at Palo Alto, California. With the bombing of Pearl Harbor, there was an ensuing mass hysteria on the West Coast which resulted in mass evacuation of patients to hospitals away from the coast. I wound up in a V.A. hospital at a remote outpost at Fort Bayard, New Mexico. The hospital was situated in the arid isolation of an old army post. The medical director was virtually paranoid about the imminent danger of a Japanese air raid, and insisted on blackouts and air raid drills on command. The hospital had originally been designed for the care of tuberculosis patients, and I was "drafted" by the medical director to assist the surgeon, Dr. Claude Keeler, in thoracoplasty and pneumothorax, as surgical assistant. For recreation I grew a victory garden, read, hiked and fished, attempted to ride horses, and listened to radio reports of the war. Our isolation was made more tolerable by access to a fair library and classical phonograph records.

After a year I was transferred back to the Midwest, to the cancer surgical service at Hines, Illinois, on the outskirts of Chicago. I spent many hours as a surgical assistant and in charge of postoperative and convalescing surgical patients. The work was challenging but depressing and the staff members were rather pessimistic about their work: the mortality rate was high. I would barely get to know a surgical patient, when he would have a recurrence, and gradually waste away and die. I learned of the deaths of several classmates on active duty and began to have a sense of guilt for not being more actively involved in the war. I finally requested permission to enter active military duty.

Little did I realize that within a few months I would be in the thick of World War II in a mobile evacuation hospital in the middle of Germany. Our hospital serviced the Eleventh Armored Division in the Third U.S. Army, under General George Patton, and again I found myself in surgery, in a tent hospital working side by side with a surgeon I knew from the days of my internship. During a lull I

made rounds. My patients slept on the ground (as did the medical staff), and I functioned as a G.P. and counselor—listening to concerns about going home, getting mail from home, hoping for an end to the war (which seemed endless). At times our hospital advanced at a great pace, when the Germans were in full retreat. Some of the work was shared by German POW's and German Wehrmacht nurses.

With the abrupt ending of the war, we were assigned to the grisly mission of cleaning up the horrors of the Nazi death camps. The liberated prisoners were suffering from starvation, tuberculosis, and the results of surgical experimentation. The victims of Nazi brutality challenged all of our medical resources and in our first weeks of operation we had a mortality as high as 20 percent.

My return to civilian life more than ever convinced me of the importance of acquiring a better understanding of human behavior and of myself, and of the importance of harnessing the intelligence and energy of mankind to provide a world in which a repetition of such nightmares of violence could be curbed.

I spent the next decade in analytic training and personal analysis.

By this time I was approaching middle age. I was aware of how many years had sped by. My mentors, Paul Kramer, Bernard Kamm, and Max Gitelson, helped sharpen my perceptions and curiosity. When Paul Kramer had to be hospitalized for a cardiac condition and Max Gitelson succumbed to a coronary, my sense of urgency brought into focus my many unrealized goals.

I took time to survey my interests and to allow time for these, and to have a general idea of priorities. I made time for recreational activities. I had stopped smoking after entering military service. I became more health conscious, more prudent with diet and exercise, and learned to take better care of my physical well-being. I tried to pay attention to correcting any minor ailments, to be aware of the tendency to cope with beginning disorders by denial, to have a sensible problem of physical and mental maintenance. I tried to live a life that was balanced between profession, social activities, and recreation. I tried to broaden my perspectives by reading, travel, cultural activities, and reaching out to a few intimate friends with whom I could share these interests. I regulated my work load so that when I returned to work I rarely felt bored or "burned out."

A reasonable assessment of my health was entrusted to a few competent colleagues whose judicious advice was heeded. Instead of allowing myself to become inactive I reduced my patient load and was

more selective in the individuals I accepted for treatment. I tried to be encouraging and supportive of younger colleagues as my own mentors had been with me when I first entered the psychoanalytic profession.

I have always tried to make my services affordable to worthy individuals who cannot shoulder the burden of higher fees, and I have been rewarded by the gratification of seeing the results of successful analytic work. On some occasions I have decided to treat a needy individual without charge, and I have never regretted undertaking such a task. The rewards of seeing an analysand develop as an individual to a fuller potential is a reward greater than mere remuneration of a monetary kind.

A senior analyst with whom I had shared an office became incapacitated and was no longer able to practice; I have kept in regular contact with him and done whatever I could to make his plight more tolerable. The hours I spend visiting him are an investment that I greatly value. From him I have learned about the problems of the elderly and how much can be accomplished by regular empathic contact and support. His recollections from the past—a time that for him represented strength, living adventurously, and with dignity—are an understandable escape from his present incapacities. On days when he feels better, he reads *The New York Times* avidly, and he is stimulated and excited by the political ferment toward freedom in his native land and in other countries striving for a free society. His eyes gleam with enthusiasm, and I feel privileged to share this with him. On such days we can have stimulating discussions of current events as well as clinical matters that are valuable to both of us.

From the personal observations and comments above, certain practical conclusions can be made with reference to the elderly and to the aging processes: it is important to plan for the exigencies and vicissitudes of later life when one is at the prime of life. It is desirable to maintain a comfortable balance between one's physical, intellectual, and emotional commitments. It is most desirable to have an understanding of the dynamics of the processes of passing from one phase of life to another. Awareness of the gradual shift from a full career of professional commitment to a reduction of these commitments, whether by design or for other reasons, can trigger feelings of anxiety and loss; the reduction in one's medical practice, the diminution of patients, may herald a reaction of mourning which is not abnormal.

The withdrawal of libidinal investment from one's practice may continue over a period of months or years. One analysand expressed concern for his perception of the analyst's preoccupation and depressed mood as the termination of the analysis approached. He was concerned and thought perhaps he should continue his analytic work so that *his analyst* would have sufficient time to cope with the separation. As in normal mourning, this process has to be given time and worked through, and there must be a healthy reinvestment of the analyst's libidinal energies in new interests and activities, if not clinical practice. (The writing of scientific articles or books may not only contribute to our younger colleagues, but may constitute a therapy for ourselves.)

A diversity of constructive interests should have been developed all through one's years. Realistic and reasonable attention should be given to one's health; cultivation of friendship not only with one's colleagues, but with individuals from other walks of life. In these ways it is possible to broaden one's emotional and intellectual horizons. For some, the preference may be to continue professional activity in a teaching, research, or consultative capacity. For others work with a stimulating hobby may be best. A wise man once said that to live a full life, one should plant a tree, parent a child, and write a book.

For many, travel and observing other races and cultures can be gratifying. An elderly lady who was in treatment with me was literally immobilized because her husband, who was phobic about travel, insisted that she never leave his side. After his death, she not only became an enthusiastic world traveler, but successfully began to drive a car for the first time, in her seventies.

A friend of mine remarked that he wanted to live as full a life as possible so that he would never have feelings of regret of having missed something.

The ritual of retirement can be devastating for the individual who has no ability to plan for the future or who neglected to become aware of his potentials and options. In the stereotypical corporate executive, the retirement, with its testimonial dinner, gifts, certificates of esteem, the gold watch for faithful services—these do not fool the elderly retiree. He feels he's through! Where does he go from here? The retirement rituals may seem to him like the funeral for a living death. Life without purpose or function is meaningless, and the individual who finds himself in this dilemma and who cannot seek help is in what could be serious trouble.

The prevention and therapy of such a potentially dangerous depression could constitute a psychiatric emergency. I recall an elderly pediatrician who was faced with a dwindling practice, but was unable to accept professional help. He attempted to treat himself, resorted to the use of barbituates, and eventually died of an overdose of drugs. He had always been extremely proud, was an inflexible workaholic, and never allowed himself the luxury of collateral interests or activities. Had he been able to adapt to the changes in his professional status, he might have continued until such time as he could "die with his boots on." If he had possessed the emotional flexibility and security earlier in life to permit the investment of libidinal energy in meaningful and gratifying collateral interests, this tragedy might have been averted.

In the case of the individual whose poor health and strength precludes an active work program, a careful medical assessment of his residual capacities becomes a major medical responsibility. A very careful evaluation is in order. It is a disservice to such an individual to advise inactivity, if he is ambulatory: such advice can result in the replacing of his interest in life with boredom, can accentuate feelings of uselessness and helplessness, lead to further regression and isolation from his peers and the real world. Retirement, if necessary, should be gradual and, if possible, partial.

Years ago I was treating a severely disabled patient who suffered from multiple sclerosis. He once said with great feeling, "I'd rather wear out than rust out!" He continued to be active in his business until his death ten years later from causes other than multiple sclerosis. If at all possible, retirement should be *to* something, not from something.

As a psychoanalyst one is fortunate to be in a profession where one can often function well to an advanced age, and further professional development and study is an option; for example, supervision of younger colleagues, consultation, teaching, research, and writing.

For those elderly whose financial situation is favorable, the combination of family, friends, colleagues, and an empathic physician make it possible to face aging with dignity. For those not so fortunate, the process of aging, with concomitant physical and mental disability, can become a social problem which cannot be met easily with the present resources of Social Security and Medicare. For those who must be cared for in a nursing home or a custodial facility for the aged, the

expenses can be prohibitive. Some years ago, a Psychoanalytic Assistance Fund was established to meet short-term emergencies of analysts unable to afford the costs of emergencies of a medical or psychiatric nature. It would seem desirable to broaden and strengthen such endeavors in view of the deficiencies of our present medical care system at the state or federal levels.

The management and amelioration of the emotional problems of the aged will depend on the nature and extent of physical and/or psychological impairments present.

Individuals with severe incapacity from organic neurological disease invariably require hospitalization. A note of caution is in order here: it is not uncommon for an elderly individual to be misdiagnosed as psychosis with organic brain disease. When a careful study is undertaken, it may become apparent that the person is suffering from the effects of malnutrition, overmedication, dehydration, or a metabolic imbalance, as in diabetes with acidosis, or intoxication secondary to renal decompensation. An elderly individual who already has marginal cerebral circulation may, with an added physiological burden such as cardiac decompensation, present symptoms indistinguishable from an irreversible organic brain syndrome. A thorough medical survey of all elderly individuals suspected of irreversible brain damage invariably will result in the discovery of a significant number of individuals with a treatable medical condition; for example, cardiac decompensation or diabetic acidosis, which when treated may result in significant improvement of the mental functions. Cases formerly thought to be irreversibly psychotic can, at times, be brought to a state of satisfactory remission. In some instances such a remission can result in the restoration of an elderly individual's legal rights and competency.

Dehydration, vitamin and nutritional deficiency, toxemias, and anything that impairs cerebral oxygenation are among the possibly reversible conditions whose correction can lead to the restoration of a considerable degree of mental functioning.

The use of neuroleptics, antidepressants, and tranquilizers must be undertaken cautiously and with reduced dosages, particularly with drugs that have a long half-life. Occasionally, the use of oxygen may give a clue to the presence of anoxia, and improved cerebral function after renal dialysis may point to a decompensating renal condition.

The use of drugs for insomnia must be undertaken with an awareness of the danger of buildup in the blood levels of the elderly,

whose ability to metabolize and excrete these substances is usually impaired.

The potent drugs in use for cardiac and vascular disorders, such as the beta-blockers, may create a pseudopsychotic or depressive picture; a similar caution exists in the use of steroids or some of the anti-inflammatory nonsteroidal drugs. The beta-blockers are known to produce a pseudopsychotic or a depressive picture in the elderly.

Among the old standbys useful in sedating an elderly individual, whiskey, in small doses, can be extremely useful, and occasional wine with a meal can be salutary.

With refractory depressions in the elderly, there may be a place for electric shock therapy or electronarcosis, bearing in mind the increased risks in an older person with severe physical impairments.

There is a definite place for direct psychotherapy in the elderly and, in selected individuals, for a flexible and a modified attempt at insight therapy. I had an elderly patient in her eighties who benefited from supportive and empathic treatment once weekly over a period of several years. Her depression and somatic complaints diminished, and she was able to talk about her feelings and the anger she felt toward a son who treated her in an arbitrary and patronizing manner. She had isolated herself from her few friends and felt abandoned and depressed when I first saw her; but after ventilating her feelings and confronting her son with her rediscovered ability to assert herself, she took a new lease on life. Her ability to talk about herself and her feelings, to a person who respected her sensitivities and was willing to be helpful and understand her, bolstered her self-esteem to a healthier level.

The psychotherapy of the elderly should be empathic rather than overly sympathetic. Where sensitive pride is involved, sympathy will be offensive and resented. Respectful attention and willingness to try to really understand go a lot further toward bolstering self-esteem. Nothing hurts more than the brush-off with a smile. Nothing helps more than to provide a genuine human contact, even if it is on a professional level.

There should be no talk about inferiority feelings, no talk about compensatory devices, no talk about anxiety. No jargon of any sort is necessary. One must simply understand how the older person feels and conduct oneself with due consideration for the validity of these feelings.

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7

My Four Lives

Klaus D. Hoppe, M.D., Ph.D.

Und so lang du das nicht hast,
Dieses: Stirb und werde,
Bist du nur ein trueber Gast
Auf der dunklen Erde.
[Goethe, 1814, p. 248].[1]

INTRODUCTION

In his fine book *In the Image of God*, the psychoanalyst Stanley Leavy (1988) stated:

> The ancient Delphic maxim "know thyself" needs to be challenged by the yet more ancient Vedic question "How can the knower be known?" Our only answer is: With fear and trembling, and only a little at a time. This may be where Freud's phrase "the impossible profession" best fits psychoanalysis: it is truly impossible for analysts to be rid of the distortions through which we are required to see those of others. Any resolution of the ambiguity is specious; we are forced to accept that the understanding we seek to share with our patients is tentative, but perhaps that is as important as any we have to offer [p. 55].

[1]And as long as you don't have
this: Dying and becoming,
you are only a gloomy visitor
of the dark earth.

Thus, with fear and trembling in this psychoanalytic process of uncovering the concealed, I shall try to remove my own masks and to write of my four lives, how they were molded by experiences, images, ideas, ideologies, and reflections, and tentatively shared with patients.

At the end of his life, Sigmund Freud, when he had to leave Vienna under Nazi terror, changed his dictum "Our destiny is anatomy" into "Our destiny is geography." My four lives, the first in Nazi Germany, the second in Berlin after the war, the third and fourth in the United States, will demonstrate Freud's wisdom.

NAZI GERMANY

Born in 1922 in Berlin, Germany, I was brought up by a Prussian father and an artistic mother both of whom implanted doubts in me about the blessings of the new savior Hitler. These doubts were reinforced by a boarding school Gymnasium (secondary school), rooted for centuries in Protestant religion, classic humanism, and traditional patriotic virtues. Paradoxically, only through the patronage of Hermann Göring, who resided close by, could these values be saved. Every morning we listened to Bible verses and prayed under the fresco of St. Paul preaching to the philosophers of Athens. At the same time we were members of the Hitler Youth.

These external doubling processes and doubts were internalized and deepened by the persecution of Jewish friends in November 1938 and the outbreak of World War II in 1939, which I imagined to be the downfall of the world. Drafted into the army from studying medicine and sent to the Russian front in the bitterly cold winter of 1941, I was not able to maintain an identity anymore with Goethe and Hölderlin. I threw my existence toward the opposite pole, that of a reckless soldier. If I were to survive the deliberate confrontation with death, I would then consider myself as one chosen by destiny. Until the end of the war I repeated this either/or pattern; later in my third and fourth lives, I condensed such grandiose illusions into a diagram for my patients and myself (see Figure 7.1).

Whereas in early childhood, narcissism, indicated by a chain of circles, is part of normal development, later it may discard the frame of limitations and occupy the center of one's universe guarded by

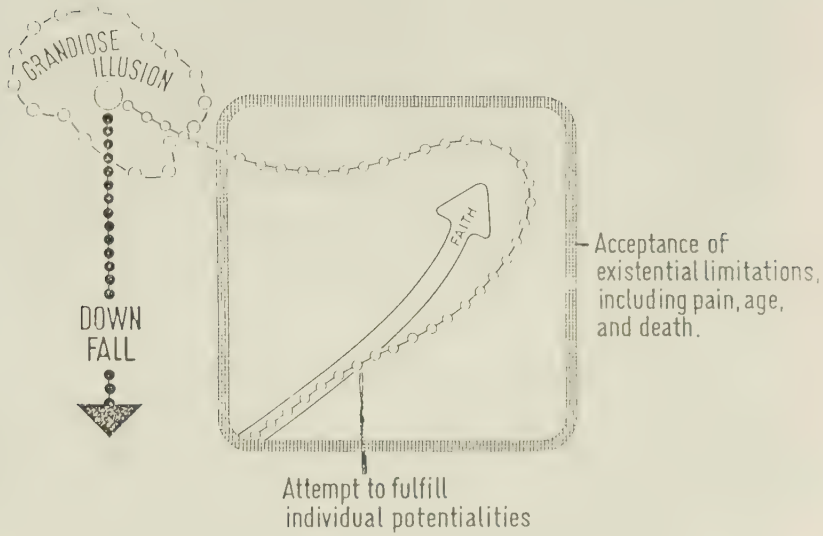


Figure 7.1

clouds of grandiose illusions until downfall into depression and despair.

In this context, the question should be answered: Why should I write of different lives and not about phases, stages, or periods of one developing life? The identity of my individual existence since 1922 notwithstanding, deeper retrospection and insight revealed cleavages, heterogeneities, and incongruities to such a degree there was the experience of being in different worlds. Looking back, I know that the young member of the Hitler Youth in 1935, the clandestine playwright of Jewish persecution in 1938/1939, the soldier in Russia, Greece, France, and Italy, three times threatened with court-martial, the student during the air raids of Berlin (1943–1944), had some of my current features, but was essentially another human being in another time.

I see him very well, the romantic idealist staring at the stars above the snowed-in forest, sleeping on frozen corpses of Russian soldiers, or hunting innumerable lice when they were energized by the heat

of the dugout fireplace. I understand how he used to cling to the ideals of the humanistic boarding school with the statue of Pallas Athene and the inscription: "Dic cur hic." I have empathy with his sexual fear, aggravated by a painful cryptorchidism, and his nagging guilt of having left behind a wounded comrade whom the fanatic communists of Leningrad would kill. Now I can only wave a farewell to him, this familiar but strange and faraway creature of the war and of the past.

This dying and the new becoming has meaning for me and for my patients.

BERLIN AFTER WORLD WAR II

"Praying in Ruins" was the title of a poem of mine, published in the first German newspaper to appear after the capitulation of May 1945, for thousands of wounded POW's in the hospitals housed in former Merano hotels in Northern Italy, then under the rule of the American army. Praying in ruins—surrounded by debris, death, and despair; praying, full of guilt and shame, for the transformation of heart and a meaningful new beginning. There were signs of hope among the ruins of West Berlin, in churches, concert houses, and theaters: from Zuckmayer's *The Devil's General*, Thorton Wilder, Sartre, Brecht, to Beckett's *Waiting for Godot*. There were even signs of hope at the Humboldt University in East Berlin, where I was permitted to finish my medical studies. This was because my father had been rescued by the Red Army from a Potsdam jail cell, where he would otherwise have been shot by the SS.

But the hope at Humboldt University died under the ruthless regulations of Russian and German communists and also my personal hope died that my play against the new terror would be performed in a West Berlin theater.

New hope developed, however, in the dim light of petroleum lamps; only two hours of electricity were allowed daily during the airlifts of 1948, from which emerged lasting trust and gratitude toward the Americans.

After a rather short period of attending lectures by Harald Schultz-

Hencke,[2] Felix Boehm,[3] and Werner Kemper[4] who tried to amalgamate Freud's psychoanalysis with Jungian and Adlerian concepts into a "neoanalysis," I joined Mueller-Braunschweig's[5] small group. He was a pupil of Freud who had established the Karl Abraham Institute (Maetze, 1971). I learned from Mueller-Braunschweig and my training analysts how important it was to have had a personal experience of an intense Oedipus complex to work through castration anxiety regarding the father, rivalry with a younger sister, and sexual clinging to mother figures.

This experience of a radical change in personal feelings and attitude remains the backbone of my therapy to this day, whether

[2]Since 1927, Harald Schultz-Hencke lectured at the Berlin Psychoanalytic Institute and supervised candidates together with Otto Fenichel. Personally courageous as an anti-Nazi during the Third Reich, Schultz-Hencke founded a "neoanalytic" association in 1946. Based on several erudite books, and intensive teaching at our own institute, Schultz-Hencke and his group became influential in the 1950s and 1960s, followed by a decline in recent years.

The essentials of Schultz-Hencke's neoanalysis could be summarized as follows:

1. Inhibition instead of repression.
2. Infantile sources of neurosis less important than postpubertal ones and the actual situation.
3. Transference, resistance, and the unconscious less significant than in Freud's psychoanalysis.
4. Dream interpretations without free associations.

[3]Felix Boehm, analyzed by Karl Abraham in Berlin in the early 1920s, published papers about world literature and homosexuality. He became training analyst at the Berlin Psychoanalytic Institute and its director, together with Mueller-Braunschweig, in November 1933. In 1937, Boehm visited Freud in Vienna who agreed that the few remaining analysts in Berlin might join the Psychotherapeutic Institute of M. H. Göring, a relative of Hermann Göring. Together with Mueller-Braunschweig, Schultz-Hencke, and Kemper, Boehm made it possible that some candidates clandestinely continued their psychoanalytic training. After World War II, Boehm taught in the neoanalytic society; he died in 1955.

[4]Werner Kemper, born in 1899, received his training at the Berlin Psychoanalytic Institute in the 1920s and was training analyst during the 1930s and 1940s. After World War II, Kemper worked together with Mueller-Braunschweig, Boehm, and Schultz-Hencke, but in 1948, he left Berlin for Rio, Brazil, where he was a training analyst for twenty years.

[5]Carl Mueller-Braunschweig, born in 1881, studied philosophy, visited Freud in 1910, and was analyzed by Abraham in Berlin in 1911. Mueller-Braunschweig's publications dealt with object relations and superego functions of females as well as relations between psychoanalysis and religion. In 1933, he became the director of the Berlin Psychoanalytic Institute, together with Boehm. In 1938, the Nazis forbade him any teaching, supervision, and publication. After World War II, at first working with Schultz-Hencke, Boehm, and Kemper, Mueller-Braunschweig founded the German Psychoanalytical Association in 1950, which became a component society of the IPA in 1957. Clearly delineating Freud's psychoanalysis from Schultz-Hencke's neoanalysis, Mueller-Braunschweig may be called the father of the now very strong German Psychoanalytical Association. All his life a "revolutionary conservative," he died in 1958.

psychoanalytic or psychotherapeutic, a bulwark against temptations to discard the essentials of Freud's insights.

At the neurologic-psychiatric clinic and hospital of Moabit in West Berlin I developed a psychosomatic team, including a physiologist, ophthalmologist, and internist, to differentiate vascular from cerebral-arteriosclerotic headaches through experimental study (Hoppe and Serke, 1958). Most colleagues in the neurologic-psychiatric department were followers of Schultz-Hencke and avoided discussions with me or with Wolfgang Loch, currently the outstanding authority on psychoanalytic theory in Germany, as to why they called repression "inhibition" and shied away from the unconscious (Wyss, 1973). The anthropological psychiatry of Zutt (1963) which I tried to understand when working at his University Hospital in Frankfurt, enhanced merely a humanistic-philosophical grasp of not only "living," but "experiencing" the body. In this area, Ludwig Binswanger's (1947) differentiation and connection between life-function and inner-life history uncovered a deeper meaning when questions were raised as to in which way and for what the "other" was motivated.

Even Medard Boss's[6] brilliant class in Zurich in 1956 puzzled me when I tried to overcome the subject–object split via Heidegger's Daseins-analysis[7] to experience my being-in-the-world as a clearing of being ("Lichtung des Seins") (Boss, 1957). Boss, however, remained a Freudian analyst in his practice and rigorously stressed the importance of transference and resistance.

Manfred Bleuler opened my eyes to view the opportunities for psychoanalytic psychotherapy with schizophrenic patients at his Burghölzli Hospital in Zurich. When a patient, catatonic-mute for decades, started to speak, maybe only a few words, the efforts appeared to us like a miracle. We thanked Madame Sechehaye (1955) for teaching us symbolic wish-fulfillment. We thanked Manfred Bleuler for his

[6]The Swiss psychiatrist and psychoanalyst Medard Boss postulated that Heidegger's philosophy, especially his "sense of being" and "care," freed Freud's psychoanalysis from technical terms and metapsychology. Boss described transference and resistance as an encounter of analyst and patient in their trusting being-in-the-world together. Understanding diseases as escape from a responsible being oneself, Boss applied his "Daseins analyse" (analysis of being) to interpretations of dreams, sexual perversions, and psychosomatic illnesses.

[7]On the basis of his major work *Sein und Zeit* (*Being and Time*), published in 1927, Martin Heidegger, born in 1899, was called to Freiburg in 1928 to succeed Husserl in the chair of philosophy which he occupied until his retirement in 1951. Strongly influenced by Kierkegaard, Heidegger delineated various aspects of human existence such as "care," "moods," and man's relationship to death.

humble, sincere humanity. When we residents reported upon the euphoric delusions and hallucinations of an old tramp who gloated over his vagrancy, Manfred Bleuler looked at us and him and said pensively: "Maybe he is happier than all of us. He is not rushing; he rests in himself."

After these experiences and having finished my psychoanalytic training at the Karl Abraham Institute, my wife and I left Germany for the United States in 1958. If questioned why, I can point to three areas of motivation: the political—I detested the massive denial of the Nazi past and the unwillingness to mourn in the new Germany of the "Wirtschaftswunder" (Mitscherlich and Mitscherlich, 1976); the professional—I hoped to practice psychoanalysis freely in the land of Lincoln without any pressure from insurance companies since in Germany at that time they restricted clinical practice and prescriptions; and the personal—to find my own identity in the liberty of distance from family and homeland.

AMERICA

Opinions after opinions: Especially at night they resurrected out of the whirlwind of the Holocaust and haunted me with the agonizing question, why my four little children, playing in the bathtub, were not gassed. Since my arrival at the Hacker Clinic in Beverly Hills in 1960, I had been writing opinions for the survivors of Nazi persecution, often fighting against the malignant prejudice of experts in Germany and Los Angeles, trying to get at least a financial indemnification for Holocaust survivors, and treating some of them psychotherapeutically. With them, I became aware of my shame and guilt and how much this aspect of my first life had been spared in my own analysis by the training analysts of the grandfather and father generations.

One morning in 1964, a chief investigator from the California Medical Board appeared in my office and confronted me with the legal consequences of having used my German medical title and having given diagnoses in my German opinions for German indemnification offices without a California medical license. I discovered that officials of the German Consulate in Los Angeles had challenged my rights to write opinions for survivors. Dr. Hacker and another American colleague, who had cosigned my opinions, were threatened with the loss of their licenses for a year. All members of the clinic

stood behind me: Dr. Hacker, using the analogy of German lawyers being permitted to work for restitution in Los Angeles without license, succeeded in silencing the California authorities. I had to control my bitterness since others were also jeopardized; instead I had to transform my anger into assertiveness and stamina for achieving my California medical license.

This task became an ordeal of four years with repeated examinations, bureaucratic obstacles, and a stressful internship. I learned from survivors who suffered from a chronic reactive aggression (Hoppe, 1962, 1971a) how to understand hate-addiction toward ourselves and the other. For them the other was often their spouse, tragically often also a victim of persecution. I developed the concept of a "Master-slave–seesaw relationship" (Hoppe, 1971b), avoiding technical terms.

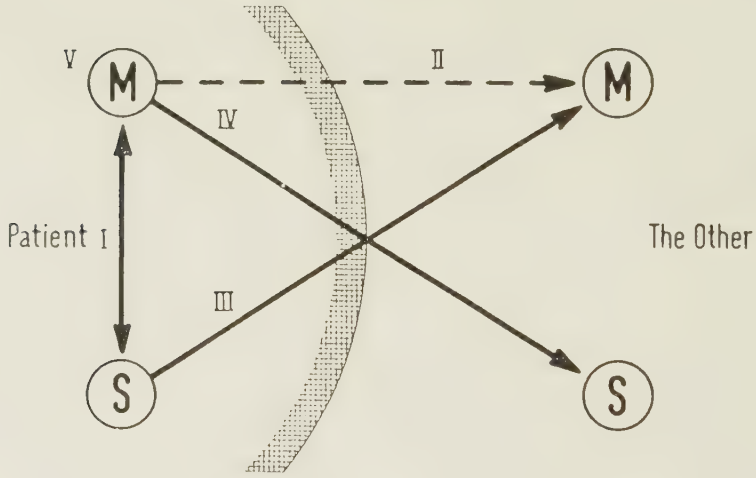


Figure 7.2

The master (M) inside the patient represents his strict and punitive conscience on a regressed childhood level; the S stands for the self in the role of a slave. When the oppression by the internal master grows unbearable, the submissive self rebels—usually unsuccessfully because the internal master is too powerful (I). An increase of oppression and depression results until the self finds a way out by externalizing the internal master; the other becomes the master (II). Now aggression

and rebellion can be expressed more easily because such an external master appears less dangerous than the internal one (III). By externalizing anger, hate, rebellion, and rage, the self gains relief and esteem and steps into the shoes of the internal master oppressing the other as an external slave or scapegoat (IV). This situation, however, evokes guilt feelings on the part of the self, in turn reinforcing the internal master (V). The process of first enslaving the self, then externalizing the master, and the seesaw relationships between the internal slave and the external master, internal master and external slave is a self-feeding one.

In psychotherapy with survivors, and during the following years with many different kinds of patients, the therapist comes to represent the "other"; at first, the external master, later the slave. If the therapist understands his position, he will accept the projected role without retaliation. This acceptance facilitates positive aspects of transference as well as explanations and interpretations. It has been my experience that repeated explanation of the seesaw relationship with its dynamics and subsequent working through supports and accelerates insight and emotional change, especially to encourage treatment motivation in psychotherapy with hospitalized patients.

During the further course of psychotherapy, more complex connections can be brought to the patient's awareness. A second diagram may illuminate the Janus face of the internal master (see Figure 7.3).

The internal master, its origins going back to the father and mother of early childhood, represents not only a punitive conscience but simultaneously a benevolent ego ideal. This inner agency—the psychoanalytic superego—demands what one ought to do and stands for what one would like to be. Because of its regressed stage, the submissively enslaved self feels guilty or ashamed. It feels guilty under the aggressive impact of the punitive conscience, it feels ashamed because it cannot fulfill the expectations of the benevolent ego ideal to which it clings. The results are low self-esteem, depression, withdrawal, as well as masochistic or paranoid features.

If the self uses the instinctual drives for its own purposes, the rebellion against the punitive conscience may lead to an aggressive incorporation or a narcissistic identification with the ego ideal. Triumph, manic elation, omnipotent or sadistic ideations and actions reflect this position.

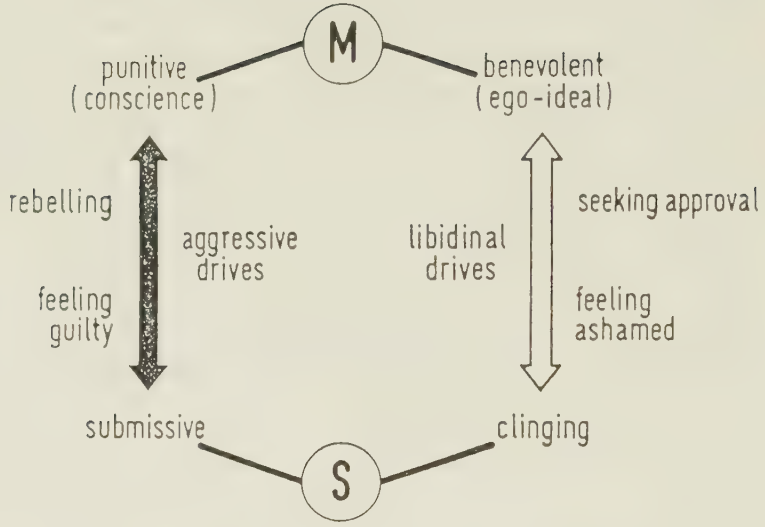


Figure 7.3

During the seventies, a new light was cast on dreams and nightmares of Holocaust survivors who for decades had repeated the experienced gruesome past without condensation, displacement, or symbolization. I found the same dreaming without dream-work in "split-brain" people where the corpus callosum had been surgically sectioned (commissurotomy) to alleviate their intractable epilepsy. Disconnected from the right hemisphere, they also revealed unimaginative, utilitarian fantasies, a concrete, discursive, and rigid symbolization, and difficulties in expressing feelings (Hoppe, 1977). Since Holocaust survivors (Hoppe, 1984a) and other alexithymic patients showed a similar pattern, I called this condition "functional commissurotomy."

These clinical findings were confirmed by an experimental study at UCLA, using a film which symbolically depicted the death of a baby and of a boy conveyed by the combination of music and visual images without spoken words, as stimulus for split-brain people and a control group (TenHouten, Hoppe, Bogen, and Walter, 1986).

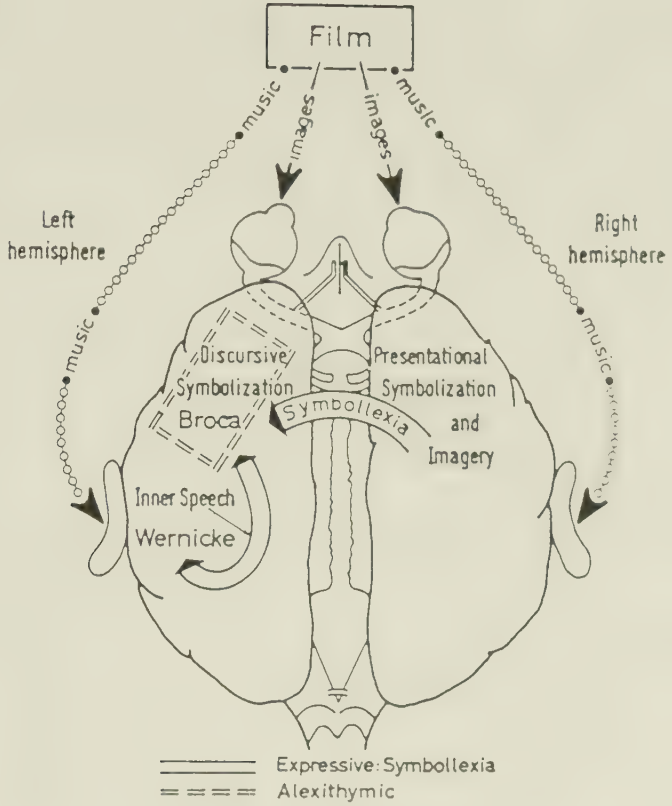


Figure 7.4

Therapeutically, the one-sided predominance of only logical, abstract, sequential, and discursive thinking of the left hemisphere, using a secondary thought process (Freud, 1911), can be counteracted by stimulation of the logic of feelings, presentational thinking (Langer, 1942), and primary process attributes of the right hemisphere via symbollexia, that is, the transcallosal transferential process of verbalizing presentational symbols (Hoppe, 1985a).

Symbollexia and hemispheric bisociation (the synthesis of two different cerebral planes) seem to be not only the basis for creativity (Hoppe, 1988), but also support the psychoanalytic metapsychology of a primary and secondary thought process (Hoppe, 1989).

MY FOURTH LIFE

In my present and fourth life, demarcated by divorce and a happy second marriage, religious thoughts and feelings came to the foreground. My therapeutic attempts to help numerous Catholic priests, monks, and nuns to work through their emotional problems (Hoppe, 1984b, 1985b, 1986) confronted me with a realm of faith and spirituality. Stimulated by Ana Maria Rizzuto's work on God-representation (1979) I developed the following diagram:

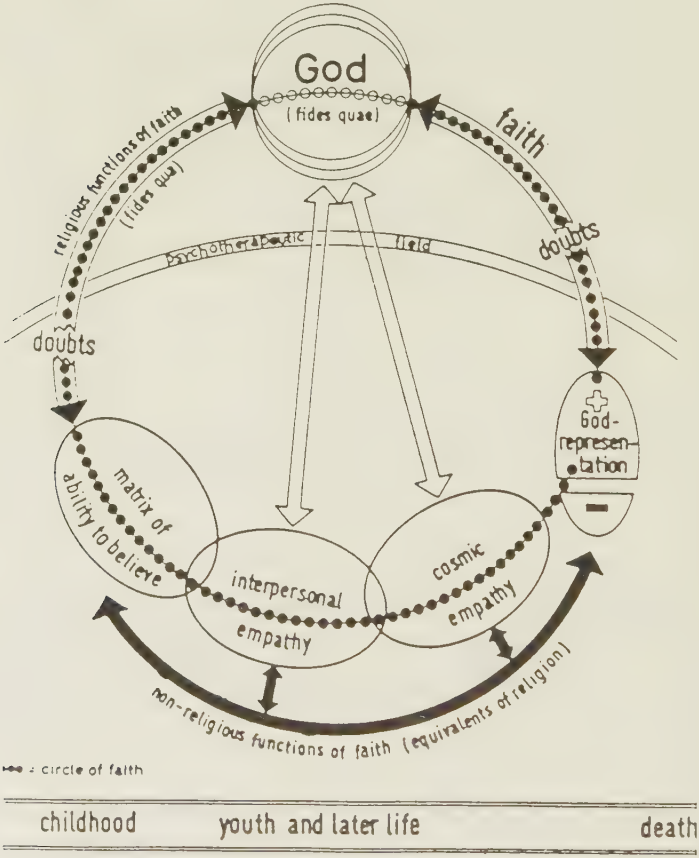


Figure 7.5

The matrix for the ability to believe is evident very early in human life. Winnicott (1971) pointed out that the eyes and the entire face of the mother are the child's first mirror. Later on, this experience becomes the first representation of God whose mirror function reflects the Biblical account of man's creation. "So God created man in his own image, in the image of God created He him" (Genesis 1:27). Eye contact as the first indicator of symbolization creates transitional space.

From a strictly psychological-epigenetic point of view, God can be understood as a transitional object representation (Rizzuto, 1979).

If basic trust (Erikson, 1963), sufficient parental mirroring, or separation–individuation (Mahler, Pine, and Bergman, 1975) of the original grandiose-narcissistic self (Kohut, 1971) are lacking, the matrix of the ability to believe is disturbed. The precursors of superego development—imitation, idealization, and identification (Spitz, 1958)—may be molded into an "inner master" (see above) who enslaves the self and is equated with the voice of God. Interpersonal and cosmic empathy may restore God-representation and basic trust and thus counteract religious doubts.

I prefer the term *cosmic empathy* rather than Kohut's *cosmic narcissism* (1975) which seems to be self-contradictory. If a person is capable of cosmic experiences, so quintessentially expressed in Friedrich Schiller's "Lied an die Freude" (1786), in Beethoven's Ninth Symphony; if empathically he can sing: "Brothers, over the tent of stars, a good father must live," then he cannot be narcissistic. If he is narcissistic (i.e., only idealizing himself), he cannot experience the cosmos.

In my treatment of Catholic priests and clergy as well as of aging patients searching for a meaning in their declining life, Kohut's concept of introspection and empathy (1971) and of "Tragic Man" (1977) were very helpful to the basic understanding of religious and spiritual feelings. His concepts of idealizing and mirror transference were applied when I realized that narcissism is not only a source of severe personality disturbances, but also the matrix for religious experiences. Without idealization of one's self and the other, there is no motivation to devote an entire life to a pilgrimage that includes celibacy, obedience, and poverty.

Catholic priests and clergy must especially work through the narcissistic fixation of "tristimania," which was described by Benjamin Rush in 1812 as the "Weltschmerz" (world sadness) of romantic artists (Edel, 1975). This "mania of sadness" is experienced as melancholic

pleasure in the role of the victimized hero. As long as the grandiose self remains split from the reality ego, a transformation of narcissism via interpersonal empathy into cosmic empathy cannot take place. As Henry Krystal (1981) aptly pointed out: "the modification of the hedonistic quality of affects in tristimania may be considered one of the basic operations in affect tolerance" (p. 101).

As the fifth figure shows, the matrix of the ability to believe, interpersonal empathy, and cosmic empathy might be effective in atheists who are using nonreligious functions of faith, such as in their veneration of Lenin at his tomb in Moscow's Red Square. As much as they may idolize him as a godlike figure, Lenin will never become God because he lacks the transcendent qualities of God.

In his synopsis of religion, atheism, and neurosis, Peter Lüssi (1979) distinguished between function of faith (fides qua) and object or content of faith (fides quae). The latter as the domain of Christian theology is defined as metaphysical entity and ontological-ethical priority. The functions of faith combine intellect with emotions, thinking with feelings (i.e., left- and right-hemispheric thinking, especially symbollexia).

A fruitful cooperation between psychotherapists and spiritual directors becomes evident by the intertwined relationship of immanent God-representation and religious functions of faith with the transcendent idea of God. Doubts in God-representations, caused by derangements of matrix or empathy, can be treated in the psychotherapeutic field, whereas doubts in faith or God need the help of a spiritual director. Constant feedbacks between interpersonal-cosmic empathy and God sustain and strengthen the circle of faith.

Widening the scope of spirituality as an awareness of a power greater than ourselves and as "God-consciousness" beyond confessional attachments (as it is done in AA groups), especially patients of our own age are grateful for the attempt to gain a meaning of their journey that is overshadowed by the closeness of death. If they are able to experience their age as a new life, creative composure is a benefit.

In conclusion, reflecting on my four lives, I dare express the hope that modern man who "gassed his soul in the ovens of Auschwitz" (Hoppe, 1984a) and exists under the cloud of nuclear holocaust, who experiences "psychic numbing" (Lifton, 1979) as a human condition and severed empathic ties to himself, to his fellow man, and to God, may learn the art of living, loving, and dying. There is a bridge of

cosmic empathy waiting for us between the shores of holocaust and atomic bomb. Hovering on the "dividing line between bios and logos" (Ricoeur, 1974), modern mankind, using symbollexia, empathy, and God-representation, may recover ourselves as the images of God.

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8

A Psychoanalyst's Thoughts on the Start of His 86th Year of Life

Martin Grotjahn, M.D.

In March 1936, while still living in Berlin, Germany, I became a member of the International Psycho-Analytic Association. Ernest Jones published this fact in the *International Psycho-Analytic Journal* after his return from a visit to the Berlin Psychoanalytic Institute (now The Karl Abraham Institute). Since then I have lived and worked as an analyst. The specific feature of an analyst's life is his interminable (self-)analysis after the termination of his formal, analytic training.

During my life I had always looked forward to getting old. It was for me the symbol of professional mastery and of continued free associative access to my unconscious. I dealt reasonably well with the changes of my inner and outer reality and never felt the need to return to another more formal postgraduate part of analysis after my training analysis with two analysts.

Slowly I grew older—but never felt old. Almost unnoticed, I developed a deep split: my self felt neither old nor young; I experienced it as ageless. At the same time I became painfully aware that my body was definitely and undeniably getting old. I became 60, 65, 70 years old and felt well, conducted my duties in psychoanalytic institutes and societies as training analyst, and other official duties. I published much of my observational research.

Dr. Grotjahn died on September 30, 1990.

Then at age 76 it happened suddenly: with one catastrophic collapse, that took me to the intensive care unit of a hospital; my clinical work came to an end.

The heart attack itself had felt like an asthma attack, quickly leading to a nameless, formless, gestaltless, paralyzing panic and night terror. There was no pain, no localized symptom—only this embarrassing, shameful anxiety, which I thought was most unbecoming for an analyst after a life in psychoanalysis. It did not feel like dying, it felt like being dead, engulfed by total nothingness, buried alive without hope and fully realizing it. My only link to the world of the living was the hand of my wife in my hand.

The electrocardiogram showed a total left bundle branch blockage and there was not much doubt about the diagnosis: coronary infarct.

Then I slowly climbed out from the bottom of despair. No free associations were possible, no dreams occurred, no faint idea of from what corner of my unconscious this anxiety may have originated. I had been sick before—kidney stone, gallstone, appendicitis—I had experienced pain, surgery, with different complications. I had lived in Germany under fascistic terror for three years and I knew death fear—but I never had an experience like this night terror.

Through all my professional life I had been a psychiatrist, then an analyst after the termination of my training. I was an enthusiastic worker in our field and to my surprise I felt no loss when I retired completely and irrevocably while still in the hospital. The necessary arrangements were made to transfer all my patients, including six therapeutic groups.

Since then ten years have passed. Against the expectation of my doctors and myself, I am still alive and living a quiet and moderately happy life of tranquility. I have to accept considerable limitations and know what would happen if I were to trespass into the indulgence of former times. I would have to pay a heavy price for it.

I have seen members of my family die, friends and patients. I always had the impression that they let go of life, and some even said it is so easy to give up, almost liberating to be free from a compulsion to live.

I did not give up. Symbolically speaking, my wife did not let my hand go. And I was and still am in love with life and with her. I cannot accept the idea that my friends will greet the sun tomorrow

morning (and enjoy their breakfast) and I will not be able to do the same.

Retirement became a time of tranquil study, even of happiness. The world was shrinking, friends came once and were never seen again (obviously a sick friend is a pain in the neck).

My son came and his visits gave me strength, especially when I had frequent angina pectoris spells. He could not do much about that, but he was there, representing the world of reality and life. In my half-sleep, he became father, brother, son, and friend.

I am an agnostic, always have been and intend to remain one. I do not have any illusion about a life hereafter. To my surprise, my dreams were dreams of indescribable beauty: about walking in high mountains with great new vistas, and through fertile valleys, with fountains and waterfalls, flowers, birds, and sculptures. These dreams were dreams of death and tried to tell me, the agnostic, that to be dead means to be in Paradise. Perhaps all beauty—even the beauty of Beethoven's symphonies—has the same meaning: life is beautiful and worth living, in spite of hardship, suffering, injustice, and even death.

These dreams had one more feature in common: the absence of my wife. She symbolizes life; she will not die because my time is up.

When I could move again, I spent much time in my two stamp-sized gardens. I realized that my flowers symbolized my patients, actually groups of patients: growing, blooming, maturing, aging.

I began to feel free: free from duties, free from guilt at doing something differently from the way it "should" be done; free from the guilt at not knowing more, how to learn more, whom to ask, and what to believe. All problems seemed to lessen in intensity, many questions remained unanswered but lost the urgency to be answered.

I felt free of the guilt not to be and to do better in my work, not to work on it any further, but to stop now.

I did not live for pleasure—I lived simply for the joy of being alive.

Not all was peace, beauty, and tranquility.

There were complications: my hearing went down, the left ear fell silent. My vision dimmed, and cataracts developed on both eyes. A bladder cancer ate its way into a small blood vessel, causing hemorrhages. How much castration anxiety was I expected to tolerate? It seemed as if something was always there to worry about.

I felt a deep split developing: Could I not send my eyes, my ears, my kidneys to the doctor, while I stayed quietly home, suffered no pain, and enjoyed the remaining time of my life?

It was not that easy. I developed a strong resistance to seeing my colleagues, always suspecting that they were thinking: "Psychoanalyst analyze yourself!" Some colleagues seemed to expect an analyst to live beyond pain—certainly beyond anxiety. The exception was my cardiologist with whom I developed a friendship.

I became painfully aware of a deepening split between my self feeling ageless and my body deteriorating.

Around that time I took up reading again, not for learning, but for the joy of experiencing intellectual beauty.

I started a new hobby besides my modest gardening, and that was drawing—all kinds of drawings. A collection of drawings illustrating the topic of "Aging Gracefully" developed. Another collection illustrates the story of a lifelong love for my wife, to whom I have been married now for sixty-three years (1990). I also did other drawings, many of them were published, all of them were accepted with delight by my friends.

Now, ten years since my retirement, I continued my self-analysis, especially when I wrote my memoirs under the title *My Favorite Patient. The Memoirs of a Psychoanalyst* (1984). The title implies that I was not only my favorite patient but also my favorite therapist. My assignment was to understand myself, have access to my unconscious, and to make peace with the past. I think I succeeded.

At the time of my immigration from Germany to America, it was my task to analyze the transfer of my German past into the American present. That was enough of analysis for the time of tension after the immigration. Later the aim of my analysis was to deepen my understanding of my relationship to my family, my colleagues, and my patients. My dreams, the events of my life, the naturalization, the military service, the sudden peace, sickness, health, and even happiness were always studied as to their reflection in my unconscious.

To write one's memoirs is one more step in the analyst's self-analysis (Grotjahn, 1984). An analyst who goes into a more formal analysis with a second or third analyst denies his duty to analyze himself. In his resistance he can fool any colleague any time. He has to learn that to fool himself for reasons of resistance can be solved only when he takes the last step to total honesty toward himself. If an analyst is not ready to analyze himself, he will probably never be

analyzed. This kind of analysis which I expected from myself is possible only when the start has been made with the help of a professional expert during the training analysis. My two analysts were easily fooled—but they opened the doors to my unconscious. From there I had to do the rest by myself.

The present state of development at the eve of my eighty-sixth birthday and my sixty-third year of marriage is a time of confirmation as it is a time of making peace with the past. I have nothing to forgive and I can hardly forget anything—but I have succeeded fairly well in understanding my life as it developed over these eighty-six years. I am going through a state of confirmation.

In the recent years of my retirement something peculiar and totally unexpected has taken place: a confirmation of my attitude toward psychoanalysis was found in recent psychoanalytic research and literature.

I read Ferenczi's "Clinical Notes—1932" (1989), and felt confirmed that without sympathy, affection, and compassion, no analysis could penetrate to the depth necessary for a "cure." (I did not go as far as Ferenczi suggested with his concept of "mutual analysis.")

In the writings of Winnicott (1975), I found confirmation of my opinion that to understand a patient and to try to help him to understand himself is more important than to alleviate one or another of his symptoms.

One other confirmation concerns a basic assumption of Freud's psychoanalysis, and that is the libido theory. I never had accepted it wholeheartedly and put the final decision off for further deliberation. I was skeptical about my skepticism, doubting my ability for concepts. I never wrote about it and felt insecure and unfinished in my theoretical orientation.

Then I read Robert S. Wallerstein's masterful review and discussion (1989) of Edelson's book on *Psychoanalysis: A Theory in Crisis* (1989). Wallerstein, speaking with the authority of having been President of the International Psycho-Analytic Association, made an astonishing statement for a representative of the psychoanalytic establishment and devastating for the original "dogma" of Freud. Wallerstein states: Edelson ignores "the whole profound shift in psychoanalysis worldwide away from the primacy of instinctual drive toward the at least equal position of relationship-seeking function of the ego as the central motivational lever of mental functioning" (*The New York Times Book Review*, February 26, 1989).

When I stood doubting the libido theory as the basis of psychoanalysis, I felt as an outsider to psychoanalysis. I made a kind of peace with Freud's original theory by assuming that it was a historical necessity to start psychoanalysis with the libido theory as a connecting link to medicine and to natural science. Having now developed the opinion that psychoanalysis should be placed not into the framework of natural science but among the Geistewissenschaften (humanities), I slowly freed myself and now feel justified by what Wallerstein calls "the worldwide shift from Freud's dogma to relationship seeking." It seems that this is the opinion of the world's community of analysts.

If I had a wish for my wife's and my 86th year of life, it is not for youth again—well, perhaps an age of 75 appears worth wishing. At that age I felt myself to be a master of my profession, of my inner reality, and to a lesser degree of my place in the world.

For the last stage of my lifelong analysis I need some more time: I want to analyze my fear of death. I want to be able to accept the end of life as an unavoidable fact of existence. My father reached that state of mind and I have already lived twenty-five years longer than he did. There is hope I too may get there.

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9

Aging

Stephen Fleck, M.D.

On September 29, 1989, my two brothers and I gathered together in Chicago for the first time in fifty-four years. It was my little brother's seventy-fifth birthday. My older brother reached 80 earlier this year and I am in between. We were a representative aging trio; my younger brother hemiparetic for several years; my older brother legally blind from glaucoma; and myself with a significant hearing loss compensated by hearing aids. It was a memorable meeting with much reminiscing, especially concerning our long deceased mother and sister, who were, of course, with us at the prior meeting which took place in Holland before our immigration to the United States.

That prior occasion was a rather tense and anxious time but was also characterized by brashness and optimism after we had grown up in the atmosphere of depression and pessimism characteristic of post-World War I Germany, and the perils visited upon Jewish people by the Hitler regime. The generally bleak view of the world besetting Germany in the 1920s was accented for us by the demise of our father in 1918. Since he had been away in military service the previous four years, my younger brother and I had only a few recollections of him. Thus, we are the product of a one-parent family, not poor until the general crash of 1929, after which we did have to count pennies. Therefore, leaving Germany and the homestead was not particularly difficult or painful and was perceived, by me at least, more as an opportunity than a disaster. This brashness served me well in the long run. Landing in New York with $200 in our respective pockets, my firm intent to return to medical school, which I had begun in Germany

and the Netherlands, was unshaken by the realities of medical student selections here. My brother and I rather soon got minor jobs through pull, whereas my sister, again through connections, obtained a job in her field as an X-ray technician. But eventually my younger brother got into a business in Chicago with which he remained until his medically enforced retirement, and I got into medical school, or I would not be writing this.

During the first year in New York City, where my brother and I shared a room in a small hotel for $15 a week, I met a good many people—some of whom were introduced through friends from Germany. Most were helpful, and eventually I succeeded in getting admitted to medical school, primarily through the help of the late Carl Binger, M.D., whose early query as to why I wanted to go to medical school or become a doctor, I answered with, "I must." I made it through Harvard and again had important mentors and friends like the late Drs. John Rock, coinventor of the birth control pill, and Herrman Blumgart, one of the outstanding cardiologists and teachers then and for another thirty years.

I mention these details because, unlike our young colleagues and medical students today, I had nothing that could be considered "career plans," and more or less fell into subsequent positions and professional activities without any game plan. After internship I headed for World War II military service for four years, an important growth experience in many respects, meeting and having to deal and work with all sorts of people whom I never would have known otherwise, and getting rid of some of my Prussian strains in dealing with people. Military experience also helped to steer me toward psychiatry in my professional thinking, because during my first year in the service I became aware of the tremendous number of psychological and emotional disabilities besetting our recruits in basic training in a newly activated division.

Later I served abroad, courtesy of the U.S. Army, and met my future wife in Bournemouth, England, just before shipping out in an ambulance company to join the clean-up of the "Bulge." After fighting through the Siegfried line, my only combat experience, I returned to Germany and became involved in the evacuation of two concentration camps and was exposed to the atrocities perpetrated by my former compatriots, and the astounding capacity for survival of so many of their victims.

After the war, therefore, I wanted to learn more about psychiatry and personal adjustments and maladjustments, especially as they might relate to internal medicine. I aimed to return to internal medicine after completing a psychiatric residency under John Whitehorn, then the chief of psychiatry at the Johns Hopkins University Medical School. Well, the twelve to eighteen months "exposure" to psychiatry which I had "planned" has lasted well over forty years now—I hope with some benefit for some patients and younger colleagues.

So here we were, fifty-four years later, my brothers retired from their businesses and I from the Yale University School of Medicine—old and handicapped but not out. As for my views on aging, it is difficult for me to think about it because in some ways I have always felt "old" from childhood on; indeed it has been claimed that "I was born old." In other ways, however, I have never felt old and even now often do not feel thus unless my aching back or more recently some other ailments bring it home to me. On the other hand, I have lived with intermittent backaches for almost fifty years and illness has always been a part of life in our family. As children, among the four of us, we experienced diphtheria, scarlet fever, pneumonias, and flu, as well as a chronically ailing mother, partly the result of her mourning the death of our father for many, many years. Even as a child I was quite convinced of the psychosomatic nature of her sickness, although I certainly did not know that term, nor did most physicians in those days.

I find it noteworthy that these early years, especially the decades of the 1930s and 1940s, are much more vivid in my head than the last three decades, which I have much more difficulty remembering accurately or even fixing dates without some assistance from a calendar or notes. I do not know how typical this is, the ever-present youth and early midlife, and how much this is connected with the relatively dramatic events during those decades covering my life from the early 1920s to the late 1940s. I cannot recall anything like a "midlife crisis," and there was only one career decision that was difficult and prolonged—not so much for myself as for the family and especially my wife. The decision involved whether I should leave Seattle where I had a part-time academic appointment and a private practice, or venture full time into academic work at Yale. I had other offers for good academic positions then and later on, as the 1950s were the expanding years for psychiatry in terms of establishing full-time departments in most medical schools.

Thus, again I benefited from external circumstances, and coming to Yale was engineered by my former teacher and close friend since then, Theodore Lidz, under whom I had worked on the medical service at Hopkins. He had since moved to Yale and begun a research project supported by the NIMH concerning the families of schizophrenics. However, after arriving at Yale, suddenly I was not only to participate in research but also to take charge of the Yale Psychiatric Institute and liaison-teaching with the Public Health Department where Dr. Ira V. Hiscock became an important mentor and friend. Again, without having planned or prepared for it, I had to master hospital administration, public health subjects, and become a clinical leader, which I suspect suited my propensity to be an elder who guides and carries responsibilities, something I had fantasied even as a child.

Interwoven with this was my analytic training—begun in Baltimore, continued in Seattle, and finished in New Haven. It clarified much for me concerning my fatherless background and tendency to find fatherly figures in friends, as well as my own fatherly stance toward friends and relatives. I owe much to many psychoanalytic teachers, but especially to the late Edith Buxbaum and Bill Pious. As for aging, however, I had little in the way of models because, with one exception, a paternal and favorite aunt who lived into her eighties, my parents' generation had passed away in their fifties or even earlier. My teachers and mentors did not seem old and most of them did not really retire, since they remained active as clinicians and teachers, with the exception of John Whitehorn who did age perceptively, having been saddened earlier by his son's death and later by that of his wife. I have followed the path of most of them and remain as active as I can teaching, consulting, and seeing patients. The major impact of aging or retirement has been my absence from the mainstream of departmental and medical school activities and politics, and as for the latter, I don't miss them.

Having been a "senior" member of our department since I was 41, I cannot account for much change related to aging in my professional work or relationships with colleagues and family. Of course, achieving grandparenthood is a milestone, but in other ways I felt no different from when our own children were born. Unfortunately we can enjoy our grandchildren only intermittently because they live 900 miles away. Becoming a parent seemed natural, like going through school, and I enjoyed our own children, having expected to have four—we settled for three when they were all under three years of

age. They all have achieved the transition from being children to having become peers, and more recently, as my wife and I have experienced more illness, have certainly taken on a somewhat parental concern, and indeed do things for us now that constitute a reversal from earlier years. Their interest, and especially that of the grandchildren, concerning my own past and stories about grandparents and relatives whom they never could know, is an important element in my life as a senior. This curiosity is less intense in a sense concerning my wife's family because her parents both lived into their eighties and nineties respectively. Thus, our own children all knew them well, especially during the years we lived in Seattle.

However, my late father-in-law was a cogent example for me, among other experiences with patients and colleagues, that retirement is wrong unless enforced by disability like my younger brother's. My father-in-law was a rather unhappy and disgruntled person in late midlife, who despite spectacular success in his career as a mining engineer and international consultant, felt himself underappreciated much of the time and suddenly retired early in a huff with his superiors, becoming, or having been depressed. He never became a psychiatric patient as such, although he made no bones about suicidal ideas early in his retirement. But even if he had become a patient, not much treatment would have been available then in the late 1940s. He continued, however, for a number of years to have consultant jobs which he enjoyed and missed when they petered out, but eventually he kept himself busy with extensive genealogical research concerning his own and his spouse's family. Through this, he left us a rich history of two American families of very different backgrounds. Unfortunately, he increasingly felt it incumbent upon himself to devote all his time and energy to the care of his wife who began suffering from Alzheimer's disease. Both of them eventually required nursing home care where he died a year before her.

Other retirees I have known as friends or patients were not as successful as my father-in-law in keeping themselves occupied, but led very inactive and unproductive lives despite continued ability to remain in practice or be productive in some other way of their choosing. Moving to the Sun Belt has never appealed to us, and I consider it a waste of human resources, even though people may enjoy their golf and bridge games on a daily basis. Many of these acquaintances I have in mind could produce and contribute in some fashion, or work as volunteers helping schools, or social agencies, and a good

many I know do, but others do not. I suspect there is less opportunity for such volunteer work in the Sun Belt than there is in the bigger cities. I have helped some elderly people with advice to that effect, even if a disability of one kind or another curtailed their energy and precluded a full-time commitment.

Of course, as we are getting older we need to face our own demise, which is difficult and always postponable. It always takes a month or two instead of a couple of weeks to get an appointment with a lawyer to review wills. Every so often I get horrified when looking at my desk and the prospect that somebody will have to clear up the mess. But I always find some reason not to put papers in order to make it easy for survivors to dispose of, or do what needs to be done. Thus, while I am well aware of the contingencies and statistics which make it increasingly likely that something fatal could befall me, I still resist translating this knowledge into sensible preparation for such an eventuality. I even resent having to take medications, let alone the appliances I need to wear, such as a hearing aid and teeth. I suspect that aging brings home one's vulnerability but is not effective enough to induce me at least to prepare realistically for the end, beyond having a last will on file somewhere.

This is in contrast to people I know who, over many years, are ready; they not only have their wills up to date, but also arrange their finances in such a way that inheritors have minimal trouble and confusion in taking over bank accounts, stocks, and like assets or real estate. Personally, I view such behavior as related to depression—realistic and helpful as their preparations may be, and this is borne out by my clinical experience. Such behavior seems like waiting (or hoping for?) death, as a terminally ill patient might realistically hope for that relief.

With so much misery in the world and blatant examples almost literally under our feet in city streets, I find it difficult to comprehend how a physician in particular, and also other nonill people, can sit at home or in the sunny South doing their own chores and not lift a finger on behalf of others, sometimes not even for friends or relatives in need. Aside from cramping their own lives, such inactivity (unless because of ill health) is a poor example for young people. Of course one aging phenomenon of which I am acutely conscious is the decline in energy and vigor. This I find most troublesome and annoying. Equally unwelcome are limitations in locomotion and manual dexterity due to arthritis.

At this point in preparing this manuscript I was interrupted by another item of catastrophic news: the wanton murder of a young nephew who had lived with us for two years as a preteen. This constitutes the latest in similar losses of the younger generation, beginning with my sister, who died from metastatic cancer at age 39; the deaths of two other nephews, one at age 3 from meningitis and another also at 39 from a metastatic cancer; and the sudden death of our son-in-law from a massive heart attack at age 40. I do not know how such events affect the aging process, but aside from my sister, the rest evoke the angry notion—it should have been my turn instead of his. As I pointed out earlier, living with death has become quite a habit and yet has not affected my nonchalance toward, if not denial, of my own mortality.

Being poor and old is a sad problem with which I am familiar, although it is not our problem thanks to my spouse's prudent management of our finances. I shudder, however, when I pay for the rather few medications we need, let alone new glasses or appliances, none of which are reimbursed by Medicare. (Medicaid is of course for the poor, but hardly adequate.) This injustice troubles me as does the even worse socioeconomic injustice and mismanagement which has over 20 percent of our children living in poverty, underfed, underreared, and undereducated. This unconscionable discrepancy between poor and rich bothers me because as we are aging it is becoming worse. But the better-off people seem only interested in their own affluence, and raising taxes and, Lord forbid, reducing our living standard as eventually we must, seems to be taboo. The old people, however, set a disgraceful example by opposing the extra tax for catastrophic health insurance.

This leads me to a related problem besetting us, although I may address a phenomenon which may be only characteristic of aging people who claim that "the old days were better." When younger, I felt annoyed when hearing this, and intended not to fall into this shibboleth. I still believe that in many respects this is not so; however, in one respect I feel with the Romans "O tempera o mores." It seems to me that there has been a palpable and deplorable change, not to say decline, in general morals and ethical behavior in our society. Some twenty years ago I wrote an editorial entitled "The Mask of Ethos" from which a few excerpts may illustrate my aging view of corrupt peers and the younger generation. Addressing our experiences with young upper-class psychopaths and their families, I said:

> Some patients' parents live beyond their income, which may be considerable, yet fail to pay their bills, although they always pay enough of a fraction to avoid the courts. Such a dimension does not represent the incorporation of deep-seated conflicts and needs into the psychic structure, but a learning process, in that the adaptive but unethical, if not dishonest, parental behavior is copied by youngsters who lack their parents' finely tuned discrimination between the unethical and the illegal.

Referring to the Watergate mess then in the headlines, I said further:

> A culture (and I'm referring in particular to the upper-middle class sector) that sets among its idols examples of instant relief, where everything and whatever you can get away with goes, need not be surprised that this combination leads to an excessive kind of behavior in young people. . . . —they may use knowledge or power in a juvenile unbridled fashion unperturbed by the consequences for those not classified as friends and the tragedies ultimately they invite upon themselves and their families.

This change in ethics and morals seems to me to have become more pervasive in public life, and politics has helped produce the increasing underclass beset by poverty, drug addiction, and violence. The "ethos"—"I do what I can get away with and never mind my poorer or less fortunate brethren—they should fend for themselves"—I find to be a stark change from the 1930s where there was more concern about the welfare of one's neighbors and the misery of the unemployed. On the other hand, I'm not sure that, as noted before, I'm not simply viewing earlier decades in my lifetime as better than what I see among our present middle-aged and younger population. Although I am aware that "the old values" are still valid for many, maybe most people, the repeated election of an empty-headed camera-wise Reagan as president makes one wonder how much people care about substance and decency. The example he, his cronies, and a spineless Congress set with their mindless budgetary policies, allowing, almost forcing us to live beyond our means and resources, bespeak a "me first" attitude which I deplore: "O tempera o mores."

Lastly, another change recently confirmed by a Brazilian colleague, who trained and worked here for seven years and returned in 1987 after thirteen years in his homeland, concerns the "modern psychiatry" exemplified by DSM-III and DSM-III-R and the emphasis on biological underpinnings of mental illness (APA, 1980, 1987). The alleged medical model of treating diseases instead of persons has

captured our field and distorted the education of psychiatrists in particular. This development I find painful and unwholesome for our field and our patients. In his (1987) Menninger Award Lecture entitled "William Osler and the New Psychiatry" Paul McHugh emphasized the biological parameter of psychiatry, but in his list of educational topics for residents I missed the study of persons as people, let alone their development as persons. I continue to believe, and hope that our colleagues-to-be will learn about people and the family's role in making them people, so that our profession can deal with people whose development has gone awry, biologically, psychologically, and socially. As Osler allegedly pointed out: "When it comes to treatment, it is more important to know what kind of patient has the disease than what kind of disease the patient has."

POSTSCRIPT

Since the preceding was written, I have had to face and am still facing probably the saddest event associated with aging—the death of my beloved spouse of forty-seven years. Sad is an inadequate term for this loss and after nine months I am not ready to write about it in any detached way. I am being cared for by children and friends, but having nobody to care for daily or nightly and intimately constitutes a painful, ever-present void. Her illness was gratifyingly brief, her malignancy too invasive when discovered to warrant active treatment. So besides talking with her about her imminent departure there was little time to really prepare for death and widowhood, which I still have to master together with becoming more realistic about my own mortality. If I live long enough, I hope to be able to write about widowhood in a more scholarly fashion as a likely contingency of aging.

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10

The Aging of Therapists

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When asked to participate in this work on aging it occurred to me that I had not seen much in psychoanalytic writings on this subject from the analyst's viewpoint. There is by now considerable work done by analysts about analysis and the aging process, analysis of older patients, but not about the analyst's personal experience with aging. Only a few analysts have dared travel that road yet. I welcomed the opportunity to express my personal views, only to run into a serious resistance to begin writing. At a meeting where several older analysts were present I asked whether they had any personal observations that would be of help to me, only to be met with jokes and light remarks on the subject. The oldest member present said, "Why is there anything special about analysts growing older?" It occurred to me then that I ought to rely mostly on my personal experience and observations.

At a recent social event a group of "older analysts" gravitated toward the periphery of the highly vocal and lively younger group, and, as usual, health became the topic. One older woman therapist asked how I was doing, and when I said, "Fine," she wanted to know how much I work. When I told her the same as always, she turned to the rest of the group and said, "Here is an example of denial of old age." I was startled and wondered to myself whether she was right. I could have told her that I do feel some arthritic discomfort in the back and I mostly walk instead of running lately, but would that have proven that old age has caught up with me? When people find out I am a physician, I am often asked, "Are you still practicing?" This has happened so frequently to me that I conclude that old age is often

imposed on us whether we experience it or not. When at the movies I forgot to ask for the seniors' discount, the young cashier said, "Don't you want the discount for older people?" and he gave it to me. At least this is one of the benefits.

When did I realize that I was aging? Although in the second half of my seventies, I am still actively involved in work with patients, teaching, and still quite occupied with the affairs of the Institute. I had to search back and try to trace the process of aging as it affected me. I have had the opportunity to work with older patients in recent years. This because some of my patients, whom I treated twenty and thirty years ago, have returned to therapy, due to their own anxiety and depression related to aging, or because of life crises with their spouses or families. In addition, because of our newly found interest in older patients it is possible that some patients, who some years back would have been treated with brief psychotherapy and drugs, are now treated with the psychoanalytic approach.

The older patient was not frequently seen when we were young therapists. It isn't that psychotherapy has gained more acceptance and respectability, although to some degree it has, but is mostly due to the fact that the population is aging. There are 60 million Americans over 50 years of age. This means that a quarter of the population is middle aged and older. Since we were not trained to treat older people we had to learn on the job, and what is more important, we learned as we ourselves aged. When we listen to patients talking about conflicts, anxieties, and depressions over growing older, that touches our own feelings, no matter how carefully we have succeeded in denying such feelings.

The analyst's own problems related to age, and the inevitability of the end of the life cycle, comes into focus when older patients express their fear of aging and fear of death. Young analysts may deal with this process as something that does not involve them personally, something distant that they have plenty of time to look at. Not so with the older analyst. There are a few important questions the older analyst ought to ask, one of the most important of which is: Is the transference–countertransference similar to what it used to be twenty to thirty years ago?

A few clinical examples may help clarify problems older analysts have to deal with that are unique to this phase of life. Let us begin with the older analyst treating the young patient.

A young woman in her early thirties wanted therapy because of depression due to her father's death three years earlier. She had just recently started to emerge from the process of mourning, although it was apparent she was not entirely out of it. After a couple of sessions I started having doubts about the wisdom of my treating her. I was interested in her case, but I was concerned about whether an old analyst was the best therapist for her. I told her that since she had suffered so much for three years over the loss of her father, I didn't think it was prudent to start analysis with an older man. Should he die while she was still in therapy, it could be an experience she might not want and I did not think she should relive. She objected that we had no guarantee that a younger analyst would not die on her, but I stood my ground and referred her to a younger colleague.

A young man wanted to begin analysis. I felt analysis was the best form of therapy for him, but I wondered again whether I should treat him. He was in his early thirties, while I was past seventy. I thought he might need four to five years of analysis, if not longer, and again I felt he ought to see a younger analyst. In this instance, however, I proceeded differently. On a walk with two younger colleagues I presented them with the problem and told them I was hesitant as to whether I should treat this man. Both of my colleagues said I should start treatment of the young man without hesitation. So I did. I have since concluded that if the analyst is in reasonably good mental and physical condition and if he still likes what he is doing, there is no reason why one cannot take on a patient whose therapy may be long.

Once the attention is drawn to the analyst's aging, a good many affects are experienced that were repressed or denied before. For instance, what is that heightened attention paid to the older patient and his or her physical symptoms? At first denied with the rationalization, "After all, I am a physician," it deserves more careful scrutiny.

Is the study of one's own cholesterol profile really that necessary? And what about the mental faculties? Is the memory still as good as it was? Why so much note taking of late? The hearing, such an essential sense in our work, is it as good as it was? Why ask the patient to repeat a statement made in a very soft voice? Maybe it was always like this and only now is one suspicious of every faculty, physical or mental.

An old man forgot an appointment. Are we going to interpret the resistance as we would do with a younger patient or are we going to face the fact that we too forgot an appointment recently. At times our older patients reflect like a mirror the image of the aging therapist. Of course we tell ourselves we know better. We have had one or two analyses. We have done self-analysis all these years. That too can be a form of rationalizing our own growing old. At a recent meeting, an older analyst was giving a talk, holding the papers in his shaking hands. He became aware of that and placed the papers on the stand, holding his hands at his side. What he had to say was still lucid and appropriate, but it suddenly occurred to colleagues and former students that it was an old man they were looking at.

Many years ago, as a young candidate seeking to refer a patient to an experienced analyst, I mentioned a name to my own analyst, who replied, "Yes, he was a good analyst, but first find out how he is aging before you refer the patient to him." This raises the issue that not all analysts are alike, of course, and not all age the same way. Years ago in our work with patients everything had to be analyzed and the basic rule was carefully observed. Are we more tolerant now? After so many years of psychoanalytic practice have we weakened or have we been influenced by self psychology and become more empathic; and if so, is that still analysis?

A problem the older analyst has to be careful about is envy. How does the old female analyst feel when her young female patients enthusiastically talk about love and starting a family and having babies? Is the aging analyst immune to regrets, particularly if she is single or childless? What of the old male analyst who listens to the ski trips, the amorous adventures of his young patients, while he has an appointment with his urologist because the prostate is acting up again? If the older analyst's marriage is not satisfactory, if sexual life has declined considerably, is the countertransference safe? The older patient who regresses and whose behavior is beneath what the analyst considers to be mature for him or his age may elicit feelings of disapproval or outright contempt from the analyst. An older man whose granddaughter needed money for college refused to help her because he needed it himself. He went out the same day and bought himself an expensive computer. The analyst could not help but express his puzzlement at this behavior. He quickly realized that beneath the puzzlement he felt outright contempt and anger at such behavior. Another older analyst felt irritated when an older patient, after years

of a dysfunctional marriage, decided to ask for a divorce. The analyst became aware that his own dysfunctional marriage should have been dissolved long ago. All the questions I have raised are only signposts that remind us of the hazards of old age in the life and work of the analyst. These problems are not unique to the old analyst, but may become more poignant to the older analyst. Of course we would like to think that the old mature analyst has lived his life fully and has a gratifying, serene old age. Has he matured to what Erikson called "involved disinvolvement"?

We remember brain anatomy and ask ourselves how many are left out of the 10 to 20 billion nerve cells we had when we were young. Is it evident that many of our brain cells are gone when we forget where we put the car keys this morning and lose a book? We feel reassured when we read that a global decline in brain structure is not a necessary consequence of aging. Or are we using denial? We also read that changes occurring in old age don't necessarily have to be entirely attributed to brain changes or to changes in the life of the individual. That is reassuring. There are no major changes in our life. Besides, it has been proven that the brain has been found to be far more flexible and adaptable than previously thought. This is great news indeed. We psychiatrists are more fortunate than our colleagues in other specialties. The brain is our major tool. Very few specialties in medicine require so few physical skills as does our specialty. If our brain functions well and our hearing is still good (if not, it can be enhanced with a hearing aid), psychiatrists can work until advanced old age, more so than other doctors.

We ask ourselves how competent we are as we age. Are our skills still as good as they were when we were younger? Other physicians have their senses to validate their ability and skills. We rely on our memory and our capacity to empathize in order to know that we are doing well. But, do we keep up with the new developments in our field? This becomes more poignant if we are still engaged in teaching and a young student or resident asks, "Are you keeping up with what is going on?"

How have we aged psychologically? Are we as flexible and open to other people's feelings as we used to be? Have we become skeptical or outright cynical about life? Do we empathize with the struggles and sufferings of younger people? And what is more important, do young patients feel free to entrust their feelings to an old therapist? We remember Freud's angry reaction when Hilda Doolittle failed to

develop a positive transference when in analysis with him. Pounding with his hand on the sofa Freud (Doolittle, 1956) said to the American poet: "The trouble is I am an old man, you do not think it worth your while to love me" (p. 93).

One finds that the older therapist becomes more readily a parental authority to younger patients, and oedipal conflicts are brought to the therapy irrespective of the age of the therapist. Maybe if Freud had been more patient with Hilda Doolittle she would have experienced sexual feelings toward him. In my own work I treat older people, not by choice, but because as one ages I notice a tendency among colleagues to refer older patients to an older therapist.

An older patient nearing his seventieth birthday became depressed. He was single, in love with a woman who, although good to him, did not fill all his fantasies of what an ideal man-woman relationship ought to be. As I worked with him through the depression I understood well his struggles with age and illness and without any parameters or special technique adapted to him, I patiently waited for him to improve. When he came out of it he called me on the phone and said, "Thank you for being you." I think by being old, and even older than he was, added to the work we did together. He may have experienced a certain empathy that I was not conscious of expressing.

A unique opportunity presented to an older therapist is to have treated more than one generation in the same family. In one family I have treated the grandmother, the daughter, and the grandson. It allowed me the interesting experience of watching family dynamics and the life cycle for about thirty years. It also presented me with the rare occasion to see my work through the years. I could tell my own development as a therapist through these patients. Did the grandson benefit more than the grandmother by my increased knowledge and therapeutic skill? I have not found an answer to that, but it may make an interesting study.

An interesting observation available to the older therapist is the return of the older patient. The patient whom we treated thirty to thirty-five years previously who returns because of changed life situation, loss of a loved one, or changes in health offers us a unique view of how our work with them has stood the test of time, and it enables us to observe how the older patient has made use of our earlier work. If the results were good, it reaffirms our trust in the basic principles, but we ought to be careful before patting ourselves on the shoulder.

The patients that return to us after so many years may be the successful ones. What about the others?

In working with older people one doesn't observe great differences between their neuroses and those of younger people. The same conflicts, the same defenses are there. If there is a difference it is in the coping methods. The older person has less time left to modify the environment to suit the neurosis. Divorce, remarriage, new business, change of place, all means through which a younger person tends to act out conflict or to resolve conflict in therapy, are not as available to older patients.

Being an older therapist one has the opportunity to treat older colleagues and their families. This allows us to compare our aging with that of our peers. I don't know whether this tells me more about myself. Comparisons with colleagues in therapy are not conducive to an objective therapeutic stance. One interesting observation, though, is that the older therapist in therapy with an older colleague develops a dependent transference on the therapist, as if to say, "I am glad there is someone left I can rely on and be helped by."

Another issue which deserves some thought is the relationship between the older analyst and his or her younger colleagues. If he still teaches and supervises cases it is not unusual to hear his established concepts being questioned and for him to be asked whether he is not behind the times. If an older analyst questions new theoretical and clinical ideas readily embraced by younger colleagues and by former students, not infrequently he may be met with criticism or with outright accusations of being too conservative, which implies too old. There are older analysts who are suppressing their scientific disagreements for fear of being considered out of step and too wedded to ideas which have been superseded. At scientific meetings one can notice older analysts rarely questioning statements by younger colleagues for fear of appearing rigid. When one older analyst was asked whether he really agreed with what was said, he replied, "No, but what is the point of entering into an argument," and that was a man known to enter into heated scientific discussions.

Freud (1905) felt that after the age of 50 the "elasticity of the mental processes, on which the treatment depends, is as a rule lacking—old people are no longer educable" (p. 264). Can we confirm that? A man in his late sixties came into therapy because of a severe narcissistic insult suffered when he was discharged abruptly from a very prominent position he had held for several years. Up to that

point he had functioned reasonably well. What became evident in therapy as mentioned above was that his mental processes lacked the elasticity necessary to overcome his crisis and adapt to his new life situation. His sessions consisted mostly of associations related to his past when he was successful and his World War II exploits for which he received decorations.

Another man of the same age came into therapy because of a serious loss. His wife of twenty years had left him. He was seriously depressed and suicidal ideation was often expressed. However, in the transference he expressed trust and hope and he began to emerge from the depression and fantasied a new life in the future with another woman. Here we see the mental elasticity to be present and well utilized in the therapeutic process. How does this relate to the aging therapist? In the first case, I was reminded of a colleague who retired in his late seventies and shortly after became depressed. This was a man who functioned very well in his earlier years, was mature, and was often consulted by younger colleagues for guidance with difficult cases. When I visited him in the hospital he had regressed to earlier neurotic behavior which, while active and useful, were compensated well. Acute situational crises in old age may disrupt what was otherwise a well-defended earlier life pathology.

The second case was reassuring and gratifying. It reaffirmed my conviction of the usefulness and the importance of psychotherapy with older patients. Seeing such positive results with older patients encourages us to continue to work with our self-analysis, and, in particular, the habit of analyzing our own dreams receives added impetus. Both patients mentioned above exhibited what George Pollock (1987) defines as "Mourning Liberation" (p. 51). They both displayed a mourning for the past states of the self; however, one was able to liberate himself and move forward while the other could not.

Older patients can also be therapeutic for the therapist. Older patients come into therapy because of life crises and problems connected with physical illnesses. Older patients, both our own patients who return to therapy after many years and new ones recently referred, turn to us with greater intensity than the younger patients. We become the object of powerful transference feelings, as Nemiroff and Colarusso (1985) also observed.

An old man, divorced, living alone, his children living in another state, found in the therapist the only person he could talk to during the week. In addition, dealing with his depression he looked forward

to the sessions because he could discourse on various topics he read in the paper or a film he saw, and there was no one else to do it with. It takes much sensitivity, empathy, and involvement on the part of the therapist. The older therapist can better identify with such needs, more so than a younger therapist.

Looking back at several decades of work with patients I wonder at times why we persist in our work even though most physicians our age have already retired. This came vividly to mind in relation to two clinical examples that occurred recently. A woman, 70 years old, came to see me because of depression following the death of her husband. The relationship with her husband was not very satisfactory, but they had lived together many years and she suffered the loss and the loneliness. To add to her pain, just before he was wheeled into surgery for a coronary by-pass they had an argument and he accused her of not caring much about his condition. She experienced considerable guilt since she had thought on and off over the years of leaving him. We worked her problems through and made considerable progress. In spite of her age she demonstrated a good deal of ego resiliency and she regretted she had not sought therapy years before. At this time fate intervened and she developed a rapidly progressing malignancy. For the last six months of her life I visited her once a week at her home. She felt I helped her considerably during her illness. She was not afraid of dying and maintained a sense of humor to the last. I saw her in the hospital before she died. I took her hand and from behind her oxygen mask she blinked her eyes in recognition. I went to her funeral. As I walked away from the cemetery I felt more sadness than I should have felt. I wondered whether it was due to the fact that my own parents and a sister were buried there. I also wondered about my own feelings about death. After all, this patient was younger than I was. At the time I asked myself why I had done this. Wouldn't it have been better if I had spent that morning playing golf?

The second case that recently had me asking the same question was that of a man who just turned 50. He appeared well defended against a depression he had suffered several years before and was making reasonably good progress when he underwent surgery for a prostate problem. Following the surgery he developed serious sexual difficulty (he was otherwise sexually active). Shortly after, to my surprise, he deteriorated, and the old depression resurfaced, and I was concerned about his condition. Since we had developed a good working alliance and a positive transference, I kept frequent contact with

him in between sessions, including calls I initiated on weekends. Here too I asked myself, why I was doing this.

Following Franz Alexander's suggestion, I have given my telephone number to some patients while on vacation. Alexander claimed that his patients never abused it. He said it was a good corrective emotional experience for some. I had the same impression until recently, when one patient tracked me down at a Congress in Italy, and while there I initiated a call to another patient. Why am I doing it, I asked again? Of course, there are other experiences that keep us involved with people, and their experiences enrich our lives too in our older years.

Ella Freeman Sharpe (Wahl, 1966) expressed beautifully why we are in this profession to begin with, and I think it applies very well to the older analyst.

> Leaving now the deep unconscious gratifications that our work can give, we must demand of ourselves that they be genuine sublimations. Apart from the obvious one of earning an income I will name a possible final one. Its roots are in the unconscious and they too are obvious. While our task lies primarily with the unconscious mind of the patient, yet personally I find the enrichment of one's ego through the experiences of other people not the least of my satisfactions. From the limited confines of an individual life, limited in time and space and environment, I experience a rich variety of living through my work. I contact all sorts and kinds of living, all imaginable circumstances, human tragedy and human comedy, humour and dourness, the pathos of the defeated, the incredible endurances and victories that some souls achieve over human fate. Perhaps for this I personally am most glad I made my choice of psycho-analysis, the rich variety of every type of human experience that has become part of me, that never would have been mine either to experience or to understand in a single mortal life, but for my work [cited by Wahl, 1966, p. 270].

What is it that attracts us to this profession dedicated to work with the patient's emotional life? I had the opportunity as dean of a psychoanalytic school for several years and teacher in the psychiatric department of a medical school to observe and study the motivation of young people applying for training. I found the usual answers not very satisfactory. I had to rely more on my own experience and the observation of the young men and women I analyzed. I underwent my first analysis several years before applying for training. At the time I considered specializing in internal medicine and I had a one-year residency when I started the analysis. I lived in Europe during

World War II and I was fortunate to escape the Nazi juggernaut, but it took a good deal of running and hiding, and even when caught, I was lucky enough with false papers to evade a bad fate. When the war was over I felt rather smug about my ability to extricate myself and at times to offer help to others too. My gratified narcissism was dramatically shaken at war's end when I experienced anxiety attacks. Today one would call that posttraumatic stress syndrome. Underneath it all the old neurosis made its appearance. That was what took me to analysis, and only after I realized what it did for me, did I decide that it was what I wanted to do. I still think that the most valid motivation is the personal experience. And what about my students? No matter what response we get, I still think that most people are attracted to analytic training and very likely to psychiatric training in general, for personal reasons. I found a great number of applicants who suffered from depressive symptoms. Some applicants had one parent who committed suicide. It is true, we are dealing with a self-selected, highly motivated group of men and women, but at the emotional level a depressive constellation is often what motivates some toward psychiatry and psychoanalysis. How does this then influence their personal and professional life? This is hard to answer and may some day become an important research subject.

If only social and intellectual contacts are viewed, most of my colleagues who have reached their late sixties and early seventies seem to have aged well. Their intellectual interest in new theoretical and clinical involvement is quite active. If neurosis or depression was for some the original motivation, their personal analysis and their work with patients has offered them a good opportunity to sublimate and to adapt well to the various stages of the life cycle. I add work with patients because I believe that our work with patients is therapeutic for us too. It stimulates our own self-analysis. It keeps our interest in our own dreams very much alive, and I doubt that this would take place if we didn't work with patients. I know of no other human activity that motivates one to examine one's own dreams, slips of the tongue, or any other parapraxes as our profession does. What man or woman in their seventies would spend time to understand last night's dream? Unfinished work in our own analysis gets many chances to be continued by a patient's association, or dreams or a transference situation.

Of thirty to forty students that were enrolled in our psychoanalytic school in the early fifties, I recall two suicides, maybe one or two

divorces, and no other major crises; at least none that became known to most of us. What does this mean? How do we compare with other doctor groups and with the general population? On the face of it, we compare well. Maybe because we are a self-selected, highly motivated group, or perhaps, as I often think, because our work as we advance in age becomes somewhat therapeutic in the sense that we learn from our patients.

We look at our patients and see ourselves as in a mirror, a distorting mirror, but nonetheless the aging therapist cannot help but feel some of the feelings his older patients experience as a reflection of his own concern about old age, illness, and death. Is the preoccupation with illness and death in our older patients an exaggerated fear in an otherwise vulnerable individual, or is it part of what we all experience? Is the sadness of mourning of the older patient the experience of the vulnerable patient we treat, or is this something we deny in ourselves? What about their hypochondriacal concerns? Is that a symptom of old age? Aren't we seeing our doctors more often than necessary lately? Our patients often complain of feeling abandoned by family and friends. This results in deep narcissistic insults to the self. How come we are less enthusiastic about social activities, when as younger people we looked forward to them? Have we come to recognize the fatuity of the functions, or are we too withdrawing our interests from people and events? Are we as eager as we once were to go to meetings? We tell ourselves that we have heard these topics discussed before, and there is little new to maintain our interest. Is that true? An analyst who has been involved in many political and scientific debates in and out of the Institute, when asked at a social event how he was doing, replied heatedly, "I am fine. I just turned 75 and don't give a shit anymore." He probably meant he did not care anymore how he was perceived. Some detachment does take place as we grow older. Is it anticipation of the approaching end, or is it wisdom and cynicism?

I do think that the older therapist becomes more selective and less tolerant of subjects and people who have little to offer. Maybe that is wisdom as Erikson would have it. Erikson (Erikson, Erikson, and Kivnick, 1986) assigned to old age, "A tension between a sense of integrity and an opposing sense of despair, accepting life as one has lived it and a future which is wholly certain and wholly unknowable" (p. 54). Then one is looking for the final strength: wisdom—"The detached concern with life itself in the face of death itself" (1986, p. 54).

This brings us to wisdom. No matter what theoretical point of view we follow we basically spend a lifetime helping our patients to live better lives. The implication is that we ourselves possess that quality, wisdom, that we clearly dispense in our professional lives. There are patients who are more talented than we are, better educated, and more intelligent, but if we have anything they think we have and they don't, it is the wisdom necessary to develop a better life. Philosophers will agree that wisdom is not knowledge, not education. Maybe wisdom is the quality of being able to bring together knowledge with action. We try to help patients develop a way of life, free of pain, free of fear, and to develop the wisdom to avoid unnecessary struggle. But what makes us think we ourselves possess that quality—wisdom? Socrates refused to call any man wise because he felt that wisdom belongs to God alone, but our patients idealize us. They have the need to think that we are possessed of wisdom and that we can impart it to them. The aging therapist is past the time when he feels his narcissism titillated by his patients' admiration. It takes a greater effort at this age to withstand the onslaught of the negative transference, and the positive one is not as warming as it used to be. Is this as good for the patients as it is good for the therapist? I have the impression that it makes for a "calmer" therapist, and maybe the Roman philosopher Lucretius was right when he said that calm and repose are attributes of the wise man. In that respect the older therapist may have achieved that stage in life, and if he hasn't, it is still a good aim to pursue at any age.

The most important aspect of old age is the recognition that sooner or later, and possibly sooner than later, death must come. How does the therapist deal with the universal anxiety about death? After all, we spend our professional lives helping people learn how to live better. How do we help our old patients who are seriously ill and really facing death? How are we dealing with our own anxiety and our finality? The future is not infinite as we thought when we were younger. By this time we have witnessed the death of relatives, our own parents, and of close friends. We know from Freud that in the unconscious we know nothing about death in general, and of our own death, in particular.

Ernst Simmel said to Grotjahn, "We all die of Freud," meaning Freud was too big to all of us and any compromise to adjust to him is too difficult (personal communication from Martin Grotjahn). That is a difficult role model. With all Freud's human frailties, it is still not

easy to think of one's own life lived "according to Freud," and this is not even necessary or desirable. However, when one thinks of how he faced fourteen to fifteen years of a painful and incapacitating illness and still continued to write and create works that are cornerstones of our knowledge today, it is difficult not to be in awe of the strength and the determination of his genius. We are not made like this. As for how he faced death, we know from Max Schur that few people would behave like that to the end. It has the characteristics of Greek drama that cannot but move us deeply. It is, therefore, better that we try and find our own way in old age and prepare for the inevitable end, if such preparation is possible at all.

Do analysts who reach this late stage develop wisdom and detachment concerning life itself? Do we notice that? Do we experience it ourselves? Do we accept the sadness that goes with old age, or is it denial that prevails in most of us? Freud (Doolittle, 1935) expressed it in a letter he wrote to Hilda Doolittle when he was 79 years old on receiving a present from her. "It is hardly advisable to give an octogenarian something beautiful. There is too much sadness mixed in with the enjoyment" (p. 178).

Wisdom, as defined by Erikson, is involved disinvolvement. In a sense what is meant is the capacity to adapt to old age without the despair that life is coming to an end. To return interest and involvement in the life around oneself without denying the finality that is not far away. The ability to maintain contacts with significant people, I find to be one of the most significant signs of how an older patient is doing. Whatever the conflict, whatever the depressed feelings are, if there is a good deal of contact with the younger generation I find the prognosis of the old-age neurosis is favorable. The very fact we are still working, we are still immersed in the lives of people of all ages, contributes to our feeling of still being important in other people's lives.

The colleague who retired in his late seventies and shortly after entered into a serious depression said, "Don't you ever retire." Of course this case raises another issue not necessarily related only to the older therapist. Don't some therapists function reasonably well because the work with their patients allows containment of their own neurosis? The fact that they are still needed by their patients may also contribute to their well-being and self-esteem.

We don't all age alike. We bring to old age different genetic and environmental constructs; therefore, it is difficult to generalize from

person to person and from patient to patient. But when we think of our colleagues we do have something in common; the attraction to this profession and the similar working conditions. If we accept with George Pollock (1982) that we all go through a "Mourning Liberation" process, a universal transformational process that allows for the adaptation to "change, loss, transition, and dysequilibrium" (p. 276), we can say that those therapists who continue to work in old age seem to have adapted well to the loss that is inherent in old age. An important realization by the aging therapist is that the life cycle continues. One still evolves intellectually and emotionally. Our patients, our colleagues, our friends, and families are a continuous source of interaction that age does not interfere with. That may be one of the reasons why therapists tend to continue working even into advanced age. This view is also confirmed by Nemiroff and Colarusso (1985) in their work with older patients.

Having traveled our own old age reasonably well enables us to relate to our older patients with care, empathy, and sincere interest in them, something not always present in the young therapist. There is though a sadness that accompanies old age. A sadness that does not only mourn the past, but also the future—the loss of what one will not see anymore. There is the sadness that is experienced at times by older people, of what will never be again. It is this that probably Freud meant in the letter to Hilda Doolittle when he mentions sadness mixed with enjoyment in old age.

Martin Grotjahn (1985) says that guilt goes with our work: "The feeling of never being as good as one ought to be to help somebody" (p. 296). Do we really solve our problems and do we help our patients to resolve theirs? We hope we do, but we do help them to make the "voices distant," and as we grow older I think it is an achievement if our own voices get distant too. Conflicts are not as vibrant as they used to be. I don't think that is detachment due to aging. Calm and repose, as the old Roman said, being the sign of wisdom. Maybe that is what old age is all about, a calm and repose acquired during a life of struggle and conflict.

As a young physician and a resident in psychiatry I had given very little thought to what my old age would be like, but now that I have reached the last phase, I don't think I would have done it differently. I could not see an emotional and intellectual life involved in so many people's lives suddenly interrupted by retirement. I could not

imagine spending days on the golf course or sailing a boat instead of listening to people.

I can see giving up one's work due to serious illness, but if the aging therapist is in reasonably good health, there is no better place to be than where he has been for the last thirty to forty years. The ancient Greek physicians upon graduating from medical training used to sacrifice a rooster saying, "I owe a cock to Esculapius." We ought to say we owe one to Freud.

As for the question, do we know more or have more to say about old age and the end, one ought to be content with Montaigne's statement about old age that the journey, not the arrival, matters, or as the Prophet Joel said about the life cycle some 2000 years ago, "Your young men shall see visions and your old men shall dream dreams."

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11

An Analyst Grows Older

Jarl E. Dyrud, M.D.

In medical school I had thought and read a fair amount about the development, maturing, and aging of the body, but any thoughts about the psychology of aging came much later in my development as a psychiatrist. We did learn in residency about the expectable behavior of this or that age cohort of our society. Age-appropriate behavior was a significant aspect of psychological assessment. This was in the 1940s when children still knew that they were expected to be seen but not heard, adolescents were just beginning to be heard, young adults knew their expected roles and how they differed from the well-established middle-aged norms, and then there were the elderly. Some people began to act elderly at 50 because it was such a familiar set of behaviors. It had a charm to it. For the person who played it reasonably well, there was respect and consideration available both in the family and on public conveyances.

Early in my psychoanalytic training we studied child development intensively with the implicit assumption that everything that happens subsequent to age 5 is playing out the hand that was dealt in those early formative years, unless, of course, one is analyzed or has a particularly fortunate life experience. It never occurred to us that big changes can occur when one changes one's mind. Later on, in Erikson's monograph on *Identity and the Life Cycle* (1959), we did encounter his adult stages which suggested that there was more opportunity for change in adult life, but this work was more speculative in tone, lacking the imperative quality of Freud on early childhood.

After coming to the University of Chicago in 1968 I became acquainted with Bernice Neugarten and her research on the life cycle. It quickly became apparent that if my age-appropriate norms ever had any real validity, they had been rapidly losing it in the two decades following World War II. Her papers on new categories like the young-old, and, particularly, "Continuities and Discontinuities of Psychological Issues into Adult Life" (1969), were eye-opening for me. This literature made it apparent that there are no reliable developmental trajectories we can project for any one person or cohort of persons except in the purest biological sense and even that is hopelessly intertwined with the psychological. More recently her book chapter with Dail Neugarten, "Changing Meanings of Age in an Aging Society" (1986), brought the whole topic of the irrelevance of age distinctions into sharp focus.

I had the magical notion that even if my personal experience showed me that there were enormous psychological differences in the day-old nursery as well as in every other age group I worked with, averaging a larger number at a step removed would smooth out the differences and give us meaningful data by which we might at least predict the probability of various outcomes. At the time I suppose I hoped that my subjective impressions of great differences were exaggerated, and that when the figures were compiled, this probability of outcomes would have a relatively small range of variation. Neugarten threw this presumption into doubt. Her paper with Christine Cassel entitled "The Goals of Medicine in an Aging Society" (1990) helped me to see that averages are grossly misleading when it comes to predicting individual outcomes. When I was 65 the averages suggested that I would live for seventeen years, six of them disabled and dependent. What this boils down to is that a few in my age cohort will become very disabled very soon and skew the numbers badly, concealing the fact that most of us will go on much as before. I hope I am one of the latter group.

What is of compelling interest to me is that nowadays individuals as well as enormous groups of individuals can and will change direction any time a new idea strikes them. This is puzzling. Our assumption has always been that customary and familiar ways of behaving have the edge on any novel variation that may present itself at any given time. This is why events in Eastern Europe recently have come as such a surprise to us. Kenneth Gergen in his paper "The Emerging

Crisis in the Theory of Life-Span Development" (1980) tries to account for this ease of changing direction in our present day by turning to Theodore Mischel who, in turn, in the 1975 Nebraska Symposium on Motivation (p. 144), reached for Kant's analysis of the emergence of autonomous self-direction in *The Critique of Practical Reason* (1788) as a way of accounting for our apparently limitless flexibility. I quote Gergen who quotes Mischel as follows:

> Central to Kant's analysis . . . is his claim that human beings can have a conception of what it is they want and what they should do in order to get what they want, and that their conceptions—the meaning which situations and behaviors have for them in virtue of the way they construe them—can make a difference to their actions. Rational beings "have a faculty of taking a rule of reason for the motive of an action" (Kant, 1788, p. 151), they have the capacity to formulate plans, policies, or rules and they can follow these rules—they have the power to act from the "mere conception" of a rule [pp. 144–145].

Later Gergen goes on to say: "From this perspective, the power of the theorist may be immense. The theorist who creates compelling theory is engaged in a form of ontological education. He or she teaches the culture 'what there is' and 'why' " (p. 54).

What is mildly unsettling to me in this is the idea that our essential human nature, aside from biological limitations, does not define age-appropriate behavior but rather our theories do. Could it have been that the revolutionary spirit in the air of the late eighteenth century helped Kant to see how it was possible to change the status quo with a new theory? At that time religion and tradition still defined roles for most people but he saw that this could change. I can imagine that he saw with some uneasiness how easily it could happen. Now after two hundred years of accelerating change it seems that we find ourselves no more rational, but faced with weakened reliance on tradition and hence an almost total absence of self-evident truths to sustain us on predetermined paths. Sometimes I think we are skating around with almost no grooves in the phonograph record. This leaves us particularly vulnerable to change.

In most cultures tradition still provides the major theory of appropriate behavior. It limits one, but at the same time there is an enormously comforting side to it. This was apparent in the English friends we were visiting this past summer who asked good-naturedly what the American press was recommending this week for longevity.

Of course they still burn leaded gasoline, and smoking has never lost its appeal to the vast majority, but they are comfortable. They are right. They know not only what is good and right, but what is in good taste. In fact the two are often indistinguishable. I am aware that the Brits have a way of tuning out anything potentially offensive in their society from the soccer riots to other evidences of social unrest arising from hopeless poverty, lack of jobs for young people, unassimilated hordes of immigrants, and an inadequate health care system. A friend of mine had a stroke and was rushed to the hospital. Here he would have had an intracranial operation because they could have had a chance at removing the clot. At the hospital they put him to bed and watched him. He recovered with severe deficit. A year later he was dead from another stroke. I was outraged. Even so, I can't help envying them a bit. In our culture we are blessed and cursed by the ease in which a new theory takes hold and influences vast numbers of people until the next theory comes along. Our "wars" on drugs, cancer, cholesterol, and hypertension illustrate the proliferation of behavioral recommendations in which the signs change from positive to negative with disconcerting rapidity. Last year soluble fiber was banned as a cancer villain until a few months later it was discovered to be good for you. There is an air of desperation in all of this that is not pleasurable at all. Obviously what we have had to do for our peace of mind is to cling to a few principles that will transcend these oscillations.

We have made a rational choice in looking to "competence" as our one guiding principle, with which we are to pursue our irrational chief value of eternal youthfulness and vigor. The track has become faster and more slippery for all age groups, but of course the hardships inherent in this abandonment of traditional age-appropriate behaviors are most apparent at both ends of the life span. Children are being driven by parents and teachers to become competent in skills which they may not be developmentally ready for. There doesn't seem to be time for childhood any more. Middle-aged people and many of the young-olds have developed enough competence to pursue youthfulness looking only moderately absurd. The elderly, among whom I count myself, mostly realize that they would look too absurd trying for youthfulness, but they still have to keep on striving for competence. It is my observation that there is no place in this modern world for a respected, wise, perhaps but a bit doddering, Mr. Chips. He was valued in the past not only out of tradition, but because he

was elderly and thus a member of a relatively scarce cohort. The newspapers have been reporting for the past twenty years that we elderly have been surviving at an alarming rate, and are becoming an ever larger percentage of the total population. It is widely believed that we hold a disproportionate share of the financial resources while at the same time drawing Social Security benefits. Even though in any one year, only a tiny percentage of the elderly are responsible for the bulk of Medicare costs—and this, largely in the last year of their lives—by the magic of averaging the well with the terminally ill we are all viewed as tottering on the verge of chronic disability (Cassel and Neugarten, 1990). This misperception may well contribute to the rash of suggestions now being offered (mostly by younger people) that we die with dignity; for example, leave a living will. One elderly man came into a community hospital recently suffering from a garden variety agitated depression and someone had written "do not resuscitate" in his chart. I hope this was at the request of a family member rather than being suggested by his psychiatrist. I am still made uneasy by the fact that a physician wrote such a nonsensical order in the chart. Is it any wonder that a certain sense of urgency develops in our drive to maintain competence.

I am in my seventy-second year, and in the last few years I have thought of myself as older in some respects, but not aged. My hair began turning gray when I was 25 so its whiteness came very gradually. Bifocals took some getting used to walking downstairs, but that was an adjustment made twenty years ago. Actually I think it was stopping smoking five years ago which brought a cascade of changes. I gained weight and developed a paunch, my allergies intensified fivefold, my blood pressure rose slightly, and I began quite routinely to feel stiff and achy in the morning. Because I am now less tolerant of coffee and alcohol I have had to drastically reduce my intake. Adolf Meyer was right when he observed that changes in the passions occur without as much upheaval as there is when one interferes with the habits of a lifetime (personal communication, 1943). I don't do exercises but walk a fair amount every day and I feel energetic. I am presenting this catalog of physical changes to get them out of the way for what is for most of us the more interesting psychological aspects of aging.

Within the last two years one of my friends developed a rapidly progressing case of Alzheimer's disease. Two others have slipped into a gentler decline but at a younger age, considerably younger than

I. Ten years ago several older acquaintances developed Alzheimer's disease. I felt sympathetic but not able to identify with their plight. Now each time another one shows signs of slippage, I feel the urge to do a quick system review on myself. When I go to let my dog out, do I bump his nose with the door because I am getting older or because he is? I am having some trouble with names, but then I always did. I have no trouble with facts, places, definitions, etc., my time on *The New York Times* crossword puzzle has not increased, yet a tiny wave of anxiety passes over me now when I go blank on a name. It occurs to me now that I may not actually be worrying about memory loss; my family tree is conspicuously lacking in evidences of senility, but there may be something else I am concealing. I do feel a small nagging obligation to conceal from colleagues my diminished investment in some of the professional activities I used to prize. This may represent to some extent a biological decrease in total cathectic energy. Be that as it may, I am more inclined to view it as a re-allocation of available energy. I have gone back to practicing the harpsichord and to painting, two activities which seemed too time consuming to be considered practicable when I was trying to accomplish some never too well defined goals in my profession. This begins to sound as if I had already retired which I definitely have not done. I had cut back my work at the university from six days a week, early and late, to one half of three-quarters time. This became possible when I was 62, so by 63 I had settled into what appeared to be a more relaxed schedule at the hospital plus a leisurely part-time practice. I wish I could say that this combination left me with considerable free time, but of course it didn't. When I reached the age of 70 a bit over a year ago, the University retired me. Nothing much changed. I still teach and supervise. I wish I could say that this combination leaves me with considerable free time which I would value because in the past I left too little time between activities to really savor them. If I were able to do that now, I would have achieved the true wisdom of the golden years. I keep telling myself there will be time for that later. Actually I feel the pressure of time more acutely than when I was 50. I am not pushing for more practice, but I do detest giving up any of my activities at the hospital and try to squeeze in more than the day will allow. Theodore Reik, in his autobiographical piece on aging (1965), said that as he grew older, he felt that by continuing, he was standing between his middle-aged colleagues and their assumption of his position. This is

not my problem. I am afraid that no one wants it, because psychoanalytically oriented treatment of deeply troubled patients seems to have become unnecessary. Even so, I do not drive on from a sense of duty as much as from trying to preserve a certain sense of self. That self, that hierarchical self, has had to go. My role is diminished and I am conflicted about it. This I view as a temporary discomfort which cannot be avoided as I move away. Here again the numbers play a large part. When there were three emeritus professors it was an enormous distinction, one could go gladly into that category, but when the number of retirees in the Division of Biological Sciences approaches three hundred, the question becomes whether we can be allowed to have a library card, to say nothing of having an office or a secretary.

People say that fear of aging itself creates some of this urgency, but truthfully, I am not running in the face of dying. I am running out of habit. If I can come to terms with this undignified scramble to maintain some sense of hierarchical potency, I can begin to appreciate the fact that I am a better therapist than I was ten years ago, my skills as a keyboard musician are coming back, even my painting is improving. It is sobering to realize that these now part-time activities, my teaching, practice, and hobbies, make more efficient use of my time than when I was employed full-time and this new pressure contributes a real element of urgency. I am not striving to make a greater contribution, I am simply doing more.

This past spring, I was talking on the telephone with my 97-year-old mother and mentioned that I was involved in trying to write a piece on successful aging. She said, "I had no idea that you saw elderly patients in your practice." I told her it was supposed to be in some part, if not altogether, autobiographical. She found this hard to believe because it was much too early for me to have much to say about it. She thought it might make more sense to write about her and her 100-year-old sister. She thought perhaps even my 93-year-old mother-in-law would qualify as old enough to interest the reader.

My mother is quite keen on this business of coping successfully as a way of staying mentally alert. She has managed our family farm since my father died in 1972 at age 80. Over the Fourth of July she flew to Chicago from North Dakota to meet her eldest grandson, my nephew and his wife, who were stopping over with us in Chicago en route to Seattle. She had no problem with flying here to meet them. She said, "It is much too much trouble for them to plan to come out to see me on their tight schedule."

Usually we have both our mothers here over Christmas and go to see them other times of the year so this was a special visit which left us with special times to talk. Talking about getting older, mother said that up to age 89 she felt generally fine for an older person. Solitude was a condition that she had become familiar with because by the time Dad died so many of her friends had died or moved away. She has always been involved in handwork, crocheting tablecloths for her grandchildren, nieces and grandnieces and nephews, as well as making baptismal towels with a lace cross appliqued on them for the church. At the age of 88 she managed successfully to sell her house and move into an apartment. She then developed a case of shingles which was devastating. It lasted for eight months and left her sense of taste impaired. Her sense of taste has improved a bit but she still finds eating uninteresting which compounds the problem of cooking for one, with the net result of her having lost considerable weight since her illness. The weight loss she says has made her wrinkled and thus looking like a much older person than she felt she was before. This was her first sense of having become one of the old-old. She feels now she must be quite vigilant about her own health care because the local gate keeper, a triaging nurse-practitioner, does not consider it worthwhile to have the circuit-riding doctor check my mother's painful finger, the same finger they did not consider worthwhile to set when it was broken two years ago. It is very clear that in this rationing of health care, the providers are viewing their elderly population as not entitled to much care whether they can afford to pay or not. Earlier I referred to Britain's inadequate health care system. North Dakota's health care is more like Saskatchewan's, its neighbor to the north with socialized medicine, than it is to the rest of the country. This is in part due to the sparse population, but also due to the Scandinavian population of both areas who have pioneered state crop insurance and state cooperative grain milling and shipping.

At best it is harder to be happy as one grows older. Feeling more at risk; having seen the finiteness of so many things, the loss of important relationships in particular, many of us tend to accumulate disappointments and have more time to think about them. It takes a hardiness of spirit as well as body to achieve successful aging.

In our conversation we discussed her 100-year-old friend Bertha's birthday party which took place this past November. The party had been a great success. It had a poignant aspect in that except for mother and my uncle's widow, she had no contemporaries left in the

community, so the guests were children, grandchildren, and even great-grandchildren of old friends and relatives. The festivities were marred only by the fact that they took place in a nursing home. Mother and I agreed that it was tragic and quite unnecessary for Bertha's daughter to have moved her to a nursing home a few months earlier. This daughter was Bertha's oldest child, and the only one living in the area. Recently she had arranged to have herself made her mother's guardian in order to triumph in a long and continuing difference of opinion between mother and daughter as to whether or not Bertha's eyesight, described by her daughter as "failing" and by her mother as "poor," made independent living, particularly in relation to cooking, too hazardous for her to continue. My mother's view was that her friend's visual problem had been with her a long time and that the challenge of coping with it successfully contributed significantly to her well-being. Bertha lived alone in a small apartment in an independent living complex for the elderly, very similar to the one my mother has lived in since she sold her house six years ago. Bertha had had a homemaker come in once a week to clean house for her, make the bed, help her wash her hair, and check on her generally. The visiting nurse came to see her monthly, but could come more frequently when needed. If the homemaker or the visiting nurse thought she required more care, she could have had someone come in every day. This would actually have been a more economical solution for the county welfare system than putting her in a nursing home. It is ironic that she is now in an expensive place where she is cared for in just those ways that are most apt to leave her demoralized and ultimately despairing.

I do not mean to suggest that in this case the daughter was being malevolent. It is more accurate to say that mentally the daughter was more aged than her mother and quite incapable of empathizing with her mother's need for independent living.

Telling this story reminds me of a 103-year-old patient I had on my ward at a state hospital in Maryland. He was a waterman on the Chesapeake, who at the age of 99 heard of something called old-age benefits. He applied, was approved, sold his boat, and shortly thereafter found himself living in a retirement home for the aged. As time went on, being a gregarious sort he made friends there and would go out from time to time for a beer with some of the men. On his last trip out he returned to find his 80-year-old girlfriend nude in her room with another man. He beat her quite severely, so he was

arrested, charged with criminal assault, taken to court, and sentenced to serve his time on my unit. This story seems relevant to the point that agedness is relative. This man was well-oriented, he knew the names of all the players on the local baseball team as well as their averages. I was a bay sailor myself and spent hours with him going over the anatomy of the bay. His knowledge of it was extensive and accurate to the tiniest detail. One day I told him his grandson, a prominent businessman in the city, was coming out to discuss with me what could be done about my patient's situation. He said, "That's fine. Go ahead and tell him all about it, but go easy on the sex stuff, he's an old man and he has a weak heart." His assessment of his grandson was accurate.

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12

A Personal View of the Age and Aging of a Psychoanalyst

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All communications by analysts of necessity are self-revelatory, but some are much more so than others. Thus papers containing clinical material reveal more about the author than do those elaborating metapsychological issues. Yet, even these often reflect projected internal needs and fantasies. Never, however, have I been faced with a more open challenge to deal with intensely personal issues. This is so, even if the eventual product will have been subtly or not so subtly polished to disguise the most painful flaws.

First I was surprised to see how surprised I could feel at being asked to participate in a venture where one of the prime requirements and accomplishments was that one could be considered an example of, and/or an expert on, aging. I temporized by asking the editor, George H. Pollock, for more information. Ultimately I had to come to grips with the issues behind my resistance, especially when, after I had brushed up on the sparse existing literature, I found myself having difficulty setting pen to paper. First there was the understandable and acceptable hesitation to reveal personal feelings of an intimate nature, not only to respected colleagues and friends, but also to those in the field who are still in analysis with me. Beyond this lay a more painful realization, namely what was attributed to Stanley Cath (Panel, 1986). As reported by N. E. Miller, the last sentence of Stanley Cath's opening remarks at a Panel he chaired on "The Psychoanalysis of the Older Patient" (1986) stated, "As humans, all are reluctant to

cross that threshold considered to be old age" (p. 164). This then was what had for a while so immobilized my pen. I was now required to acknowledge that I had indeed crossed that invisible boundary. I was committed to taking inventory of my self-representation to date; to anticipate the vicissitudes and blessings that lay ahead; and ultimately to react to possible bogeymen, the last of which must be death itself.

I agree with Stanley Cath's (Panel, 1986) remark that "Aging is not a monolithic experience for all persons . . ." (p. 163). Distinguished colleagues often differ radically on various aspects of this topic. The very definition of aging will differ from culture to culture and from author to author. Life expectancies have lengthened during the past 100 years, and the definition of the age at which one is considered aged or elderly has continued to change, and there is still no unanimity of opinion as to when this stage is reached. Optimists may insist our glass is still 1/8 full, while pessimists are equally adamant that it is 7/8 empty. Both, of course, are right. I believe it is to our advantage to understand the kernels of truth in opposing positions and see if we can abstract from them what makes it so.

I have a friend who was active professionally into his late eighties and in his nineties still is, though on a reduced scale. He has a continuing interest in and zest for life that would compare favorably with those half his age. On the other hand, I have a friend, now in his seventies, who was a very successful chief executive officer of a manufacturing plant. He chose to retire at age 55 and has been plagued with a series of physical problems which have clear psychosomatic overtones.

In this area, as in many others, we have been blessed by the many original insights Freud shared with us, and we have occasionally been burdened by his rarer incomplete or erroneous stands because there is still a residual oedipal reluctance to challenge his views. Thus Freud (1905), speaking of the age of potential patients, stated, "on the one hand, near or above the age of fifty, the elasticity of the mental process, on which the treatment depends, is as a rule lacking—old people are no longer educable—and on the other hand, the mass of material to be dealt with would prolong the duration of the treatment indefinitely" (p. 264). Freud (1932) was to repeat this rigidity theme (p. 154). There have been many analysts since then who have taken opposing stands based on their own extended experiences in treating elderly patients. Among these were Segal, H. (1958) who reported some details of the "analysis of a man who came to treatment at the

age of 73½ and whose analysis terminated just before his 75th birthday" (p. 178). In a similar vein Pollock (1980) reported having "undertaken intensive psychotherapeutic work including psychoanalytic treatment with patients in their sixties, seventies, and eighties" (p. 566). Many others have confirmed these views. Some institutes and societies now have gerontology study groups that include emphasis on the treatment of the elderly. Boston and Michigan are among them.

Greenspan and Pollock (1980) were editors of a three-volume work on psychoanalytic contributions toward understanding personality development where the last volume was dedicated to an elaboration of *Adulthood and the Aging Process*. The main theme of this book, which I reviewed (1984), is that the elderly are also part of a continuing development that like each phase that precedes it has its own stresses to overcome and the establishment of new forms of equilibrium. This was especially well dealt with in Dewald's (1980) chapter (pp. 35–53). While fully recognizing the range of vicissitudes that must be dealt with and overcome, Pollock (1980), in the chapter he contributed, takes a basically optimistic view of what can be accomplished in the treatment of the elderly who can be helped to successfully complete what he has called "the mourning-liberation process" (p. 582).

Again we are struck by divergent opinions as we explore different facets of behavior and functioning. If we take the issue of creativity we read of Eissler (Panel, 1964) asserting in his paper, presented to the panel on "Psychoanalytic Consideration of Aging," "that actually no true originality is possible in old age. What looks like original achievements in old age is brought about by a weakening of the superego and the consequent emergence of previously repressed ideas; that is to say, the seemingly creative person thrives on the accomplishments of the past" (p. 155). This in turn is balanced by Pollock (1980) writing on creativity in the aging. "Some individuals find their aging years rewarding, liberating, enjoyable—a time for personal growth, creativity, accomplishment, and pleasure" (p. 579). He then goes on to list an impressive roster of names of historical figures, whose later work was superior to that of their earlier years.

We recognize, even if we don't condone, the persisting cultural prejudice against sex amongst the aging. Often this may be expressed in humorous fashion but the underlying bias is no less telling. Thus I recently received an issue of the publication of the *Gray Panther*

Network (1989) with an article by Kathleen Smith-Fitzpatrick entitled "Mom, You've Got To Be Kidding!" In this satiric little vignette, we get a picture of the totally shocked daughter, when her octogenarian mother reveals that her current interest in an elderly gentleman is not for companionship, but because she enjoys sex so much (pp. 5, 6). Before we get too smug about this, we should be aware that we also live in glass houses. Berezin, who has written extensively on this subject over the years (Panel, 1964; Berezin, 1976), participated in a panel "The Psychoanalysis of the Older Patient" (1986) where he first reported how shocked a 29-year-old psychiatric resident was while treating a 73-year-old woman, to recognize that not only had she developed a frank erotic transference, but told him she had masturbatory fantasies about him (p. 173). This was just a preface to Berezin's need to point out that none of the analysts on that panel in reporting the treatment of elderly patients had included any data regarding the patients' current sexual lives (p. 174). Perhaps it is equally significant, even though no one mentioned it, that none of the panel described any patients having problems centered about anxiety about diminished sexual functioning. The plot in regard to libidinal and aggressive drives in the elderly is just beginning to thicken, as we note further differences in the literature. Michels (1980) seems to relegate sex and play to childhood in an almost pejorative fashion. He is willing to accept that drives and our theory of drives are prominent and useful in children. However, "With the maturation of symbolic functioning, the relative importance of organismic factors in determining mental life diminishes, along with the role of sexual (and other) drives" (p. 26). Then follow sections on what are considered the global issues of adult development among which are time, which is introduced with the following brief sentence, "Children play; adults work" (p. 30), as though the opposite didn't also occur quite regularly. Perhaps even more provocative is another elaboration by Michels of the position of the drives in aging. With aging and the progressive impairment of symbolic functioning as a result of waning capacity, "we may again see a shift toward a greater prominence of drive in the structuring of mental life, a 'second childhood' " (p. 26). I cannot, from either my clinical or personal experiences, find data that corroborates these conclusions. Libidinal and aggressive impulses may wax or wane in intensity, be directed toward objects, or inward toward our self representations, but they still color all our motivations, fantasies, and conflicts throughout the course of life. Some minor variations on this

theme may be worth mentioning here. As indicated before, Berezin's (1976) studies of sexual activities among the aged point to the importance accorded these impulses where they are not inhibited by the lack of a suitable partner or the cultural inhibitions and even prohibitions that often exist in institutional settings (pp. 189–208). His (Panel, 1986) studies show that those psychosexually active in youth continue their activity if a suitable partner is available, while others use age as an excuse to avoid previously unresolved conflicts (p. 173). Levin (Panel, 1964) felt diminished sexual activity among the elderly was not to be equated with diminished libido but only that the libido was redistributed into other areas (p. 156). He also saw cultural forces as encouraging repression of their sexual interests in the elderly. Even grown children still need to deny that their parents have sexual impulses.

Universal though we may think it to be, there can even be differing approaches or attitudes regarding the fear of death. Freud (1915), in his chapter on "Our Attitudes Toward Death," had talked about the great use of denial here but also added, "The fear of death, which dominates us oftener than we know, is on the other hand something secondary, and is usually the outcome of a sense of guilt" (p. 297). This can then be compared with Pollock's (1982) remark, "Unlike younger patients, the elderly do not fear death. At times they may welcome it as a relief from pain and anguish. Death may be a completion—a freedom" (p. 278).

The existence of a fear of death leads naturally to the question of its underlying significance and unconscious roots. Here too one's theoretical predispositions influence one's beliefs. H. Segal (1958) and P. King (Panel, 1986) postulate the fear of death from a Kleinian orientation and see behind it unresolved aspects of paranoid and depressive positions. I, however, have been struck like Freud above (1915) with the direct or indirect evidence of feelings of guilt. This is most strikingly manifest when someone unexpectedly learns they have a malignancy or they are sudden victims of a heart attack. The poignant cry may be heard, "Why me? Why me?" It is as if one can only conclude that one is being punished for some heinous crime, the nature of which is not consciously known to us. Freud (1923) again felt that neurotic reactions could help us understand normal ones. So speaking of melancholia he felt that one wound up feeling hated instead of loved by the superego which combines the function of the parents as well as destiny or fate. He further equates the fear of death

with fear of the conscience as the ultimate form of castration (p. 58). So our earlier guilt over parricidal and matricidal wishes returns to haunt us when life deals us unexpected blows. He briefly returns to this theme again (1926): "I am therefore inclined to adhere to the view that the fear of death should be regarded as analogous to the fear of castration and that the situation to which the ego is reacting is one of being abandoned by the protecting super-ego—the powers of destiny—so that it has no longer any safeguard against all the powers that surround it" (p. 130). He goes on to compare it with a traumatic neurosis. Via the notion of castration, he then also ties in the fear of death with loss of an object and separation anxiety.

It seems intriguing to me to consider the relationship between the fear of death and the situation that produces a traumatic neurosis. In both, we feel overwhelmed by forces beyond our powers to manage or control and abandoned by the protective agents of our childhood, our parents, as punishment for crimes—unconscious though they may have been. Schafer (1960) in his chapter "The Loving and Beloved Superego in Freud's Structural Theory" has picked up these themes and elaborated them in an elegant fashion. In his summary of the mature superego, he stated that, "Variations in the disposition of libido in the superego give rise to a range of feelings and actions, extending from the sense of inferiority and abandonment by all protecting powers on the one hand to pride, fortitude, humor, and effective transmission of cultural ideals on the other" (p. 187). He further postulated that both the ego and superego are involved in the binding and the discharge of both types of drive, libidinal and aggressive. One can see then that the seething cauldron that can be produced by the traumas connected with aging may seriously test the stability of the superego and its neutralizing abilities.

So ends the panoramic view of our topic with its primary focus on the voice of others on aspects of aging and its termination phases, of dying and death. It is time to end the procrastination and to fulfill the obligations implied in the title of this paper by presenting my personal reactions.

I can recall with considerable clarity an experience around my thirteenth year that left me bemused. It was the occasion of my father's fortieth birthday. A small group of his male friends had been invited over to toast the occasion. But to me a strange and unexpected note soon entered as the question was debated whether life truly

began at 40 or marked the beginning of a greased slide into senescence. I always knew I was growing up and changing, but my picture of my father to that date was of him serenely remaining the same age and perhaps waiting for me to catch up. He was a man of considerable wit and a good sense of humor. When in his seventies he congratulated himself for being in an ideal situation. His investments made it possible to meet his needs, without being dependent upon his children, while his estate wasn't large enough to invite eagerness for them to inherit their share.

When the international eruption of id forces that was to be called World War II occurred, I was still in medical school. Soon I went overseas as a division psychiatrist in General Patton's Third Army. Although I didn't consciously apply it to myself at that time, I was soon to become an active disciple of the benefits of denial. The general of my division had asked me to speak to one regiment at a time on the subject of fear, just before we were committed to combat. Since I had already made the acquaintance of fear, I felt I might speak with some authority on the subject. In essence I tried to lessen the guilt and shame connected with the presence of fear, by stressing its universality as well as its potentially life-preserving quality, if it could be kept under control and used to heighten our awareness of what dangers could be dealt with and how. I was later to learn in retrospect of how it also helped to be stupid, or not aware of how dangerous the situation was. But even this "stupidity" turned out to have a large measure of denial in it. Thus I carried an unspoken conviction, no doubt shared by many others, of a sort of magical invulnerability, so that people on both sides of me might be shot, but I would somehow survive. I suspect there was also some guilt connected with this denial of vulnerability, because I can recall the feelings of relief I experienced after the war. I was taking a course in ego psychology, taught by Ernst Kris. When the subject of defense mechanisms came up he elaborated on the theme that even defenses that are often seen as primitive and pathological, like denial, can also have important adaptive uses. But as will be elaborated later what may be useful and adaptive in one context may be harmful and maladaptive in another. This then was my stark introduction to the realities of death.

Let us take a quick temporal leap now, and recognize that currently I have just celebrated my seventy-fifth birthday. As a probable mixture of constitutional endowment and a dollop of luck, I have enjoyed excellent health most of my life with the only surgery being

a tonsillectomy during latency. I have had no major illnesses although there have been a few brief scares along the way. About ten years ago the sudden onset of intercostal neuritis brought an overnight hospitalization, to rule out the possibility of a coronary occlusion. I recall thinking while my wife was driving me to the hospital that whatever this turned out to be, I had already held a winning hand in terms of my wife, my children, my professional career, and my recreational pleasures. This is not to say I have escaped entirely the ravages of time. I have been gray for some time. My eyes show the beginnings of cataract formation, and my hearing is now electronically augmented. There is now occasional frustration in searching for a word, sometimes unsuccessfully, that once would have flowed so readily from brain to tongue. And yet my general memory is still excellent. All this does not make me insensitive to the narcissistic indignities life or fate may still have in store for me down the road. Thus in a (1981) paper entitled "Narcissism and Adaptation to Indignity" I said:

> For the adult as well as the child, life brings phase specific needs for all of us to make adaptations to the indignity life can bestow. It is how we adjust to these indignities, and even whether we can abstract from them further adaptive structures and strength that will determine at each stage the ultimate status of our self-esteem regulation as well as our relation with objects. . . . The child who wishes to replace the envied parent of the opposite sex, or the adolescent who wishes to impose his rule on the world at a time when he doesn't even have a vote, all face the task of adaptation to indignities. In later life the need to cope with various aspects of waning physical functions and strength, or accepting a younger rival as one's boss, and ultimately even the possibility of coping with the loss of control of bodily functions, are just a tiny sampling of life's indignities which almost all of us will encounter at some stage [p. 474].

Clearly the list just enumerated is not all-inclusive. Beyond failing organs and failing functions both physical and mental, there is the increasing likelihood of having to cope with the loss of dear friends and beloved family members. The problems around possible retirement, voluntary or forced, and various degrees of dependency, with a reversal of the oedipal roles where the parents are the ones who must now be protected and even managed, are all possible eventualities in store for us. We have only to visit a nursing home for the elderly to face the full impact of the darkest possible aspects of aging.

Clearly how we manage the stresses of this our last developmental stage, will depend on the summation effect of a number of vectors. First there is what we bring into this phase in the form of fixed personality and character traits; what residual unresolved or only partially resolved problems we carry from our past; our current health both physical and mental; the degree of fulfillment of life goals; the continued presence or absence of a loving, supportive partner; one's professional status and ability to continue to get gratification from related activities; the ability to find replacement interests, whether vocational or recreational if retirement is in the picture; and the ability to have a vision of a sort of immortality, through the enjoyment of the development and future accomplishments of our children and grandchildren. Undoubtedly others can add many additional and important determinants of their own.

While I cannot claim to have extensive experience in the treatment of elderly patients, I have, however, also consulted with them on occasion at the behest of colleagues or friends. Let me briefly cite a couple of my experiences, one in each of these areas, i.e., the therapeutic and the consultative. Many years ago a psychiatric resident referred her mother to me for treatment. This woman, who was then approaching her sixtieth year, had developed a combination of depressive symptoms, general malaise, difficulty concentrating, and vague but persistent feelings of guilt. These seem to have been precipitated in a previously well-functioning woman as a result of real life traumas which were the *earlier* death of her beloved husband, compounded by the more *recent* death of her only other child, her young adult son. As a part of her clinical condition, she soon revealed a regression to a state of intense penis envy, when she had felt unconsciously that she could never again be smiled upon by good fortune, unless she recovered what she believed she had lost as a punishment for childhood masturbation. Her preoccupation would currently express itself via excessive concern over the health of her bird, and whether she should buy a new one if this one died, or should just leave the cage empty. She told me, without conscious appreciation of her metaphor, that she had expected me to be a magician who could pull a rabbit out of an empty hat—but she laughed when I interjected, "Or could supply you with the missing rabbit!" This woman frequently reported losing her keys, those phallic symbols, because at some level she knew she would either find them again, or at worst,

she could have duplicates made. I can add that I felt she did well in treatment, with positive results.

The second incident is probably my fastest and most magical "cure," although I am using that term very loosely. A couple in their middle seventies were referred to me for consultation by one of their children. The children were at their wits end about what to do about their parents who were fighting like the proverbial cats and dogs. I first saw the parents individually, for an hour each, and then had one session with both of them present. Briefly, the husband had come here from Russia as a young boy and devoted his life to building an ultimately successful business, but had reached the point where his sons found him to be an out-dated and troublesome relic of earlier times. The mother, in turn, had spent her considerable energy in rearing a large family, essentially without any help. Both now lacked a raison d'être in their former spheres of importance, and each found himself and herself living with a *relative* stranger or strange relative whose faults were magnified by having to spend so many unaccustomed hours and days together. Having noted this, when I saw them together I tried to indicate the general problem, and suggested they might each benefit from some counseling or brief therapy to help them adapt to their new realities. They then looked at each other and smiled, while one said to the other in Yiddish, "Ehr is a meshugener!" (he is crazy!) and walked out arm in arm. A couple of weeks later, I received a phone call from the son who had referred them, who said he didn't know what I had done, but for the first time they seemed to be trying to find things they could enjoy doing together. I told him only, "You might say I gave them a common enemy."

It may now be clear that I have to this point been lucky enough to enjoy my personal and professional life, my children and grandchildren, and my increasing opportunities for choice in work or in recreation. Hence, I consider these my bonus or option years. And I would here like to pay tribute to that very unscientific factor we call luck. Whoever or whatever determines this distribution of luck, it is not meted out equally, and there are very important consequences that differentiate the haves from the have nots.

I will now be specific in describing the way I handled and introduced the subject of my aging into my analytic practice. It should be noted that I was fortunate enough to be able to follow my personal preferences and have between ten and eleven patients in psychoanalytic therapy, of four to five sessions a week, from shortly after I was

qualified as an analyst, until the time I decided not to take on any new patients. At about the age of 60 I began to think about both my financial projections for the future, and my feelings about the issues of retirement.

In my thoughts about retirement I was influenced by two basic considerations. I had seen some esteemed colleagues who retired at varying ages from 65 upwards with varying periods of notice given to their patients. I had perhaps been sensitized to this by my own experience in having my own first analyst stop my analysis midway at rather short notice, due to an unexpected death in his family that required an immediate move to another city. There followed a hiatus of six months while I waited for the analyst to whom I had been referred to have time for me. Further, I had occasion later to take on for a supposed "second" analysis some people who had allegedly been told their analysis was finished when their first analyst had in fact retired. These second analyses were often prolonged and bitter. Finally, I had seen respected and admired analysts who through age or illness were no longer functioning at their maximal levels but who were not aware of it.

For all of the above reasons, and for others that are undoubtedly still unconscious, I decided to do the following. At age 65, I told all prospective new analysands my age and the fact that to the best of my knowledge I was in good health. I further told them that I had no intentions of retiring at any set time but only after I had felt that my last remaining analysand had achieved all that analysis had to offer. Finally, I told them that although I was at that time taking a two-week vacation in the middle of the summer, and a similar one in the winter, I expected that I would gradually increase their length year by year until I was taking a maximum of four weeks in summer and four weeks in winter. I felt it was important that they know all this while they still had free choices, unencumbered by transference effects. Only one prospective patient whose problems centered about the recent loss of important family members chose to go elsewhere. I am certain that there will be marked differences in opinion among my colleagues about the course I chose to follow. But if it stirs up some dialogue in an area that has been strangely silent both in the literature and the psychoanalytic community at large it will serve a useful purpose. I stopped taking on any new patients shortly after I reached the age of 68, because I know analyses can last six to eight years, or even more, and I don't know how long I will be able to

function adequately. I now still have four patients in analysis; I still teach a course at the Michigan Institute, I still teach psychiatric residents in a continuous case conference; and I still am active on the educational committee and its subcommittees in my institute.

It was in fact while serving on one of the committees of the Michigan Institute that I became aware of the degree to which denial is not only present in patients; but in analysts as well. Again this is just one man's opinion, but one that is strongly held.

As part of a periodic review of the functioning of our subcommittee, the faculty review committee decided to review its operating procedures. In essence, they called for reappointment of training analysts every three years if their work was considered satisfactory, and a meeting with this committee unearthed no reasons why their status should be changed. Once one reached age 65, there were to be annual meetings with the faculty review committee and one could no longer start the analysis of a candidate after age 68 without special permission from the educational committee. Supervision could be continued until age 70, while the issue of teaching courses was still to be a mutually optional one. With the development of national laws prohibiting the use of age as a condition of employment, with some notable exceptions (such as airline pilots), it was felt that this might be a judicious time to review our procedures.

The chairman of this committee, quite wisely, first sought to call in senior members of the educational committee to have them describe what special plans they had for retiring, if any, and how they felt our own policies might be improved. I was surprised by the apparent lack of thought or planning this issue had received by this group. Some acknowledged that this subject had been on a back shelf, while one member in my age range felt there was no need for any prior planning. First he felt he would know if there were any serious decline in his functioning, and second he came from a very long-lived family so he couldn't foresee any problems in this area.

I will now present excerpts from the April 11, 1989, educational committee minutes to continue the discussion of a motion on the floor, to wit "that all age-based regulations pertaining to reviews, procedures for reappointment, attenuation of duties and privileges, and enforced retirement of Training Analysts be totally eliminated." It is to be noted that these minutes were taken down at the time by a secretary, who may have had to cope with three people talking simultaneously. Thus, in the first excerpt, when I requested permission of

the first speaker to cite his position, he looked it over and said there was a gross error in it although he couldn't then give me an edited version. As it was reported in the minutes it said "that the current procedures are based on the unproven premise, that there is greater risk of morbidity and *mortality* with increasing age; and that we should recognize on the other hand, there is much to be gained from older analysts: experience, reduced reality demands, greater acceptance of mortality, reduced omnipotence" (p. 1). I have no trouble believing that he hadn't included the word *mortality* in his original statement. He did, however, go on to make clear that he interpreted the greater frequency of review after age 65, as a form of being "put on probation" and hence an affront. He said: "a candidate entering into analysis with an older Training Analyst would not be taking any more risk due to the analyst's possible death, than loss of effectiveness from stress caused by divorce, sickness, etc." The next speaker felt that the institute had more to lose than to gain by keeping its current age requirement. Another (p. 2) spoke to a respected member of the American Psychoanalytic Association at a New York meeting, who said that "the consensus of opinion is that most of the older analysts are functioning better than they were before. . . ." He further said that "he did not see how an annual physical examination could determine how an analyst was functioning analytically." The chairman of the faculty review committee said we were only trying to set up some guidelines, that might function like the airlines' who "have a set of systems to get early warning of pilot impairment." Another member "was struck by the lack of data showing that the restrictions reduce the problems." I feel it would be appropriate that I also report my comments at this meeting as they appeared in the same Minutes.

> Dr. Segel also noted the lack of statistics relevant to the discussion, and observed that while traumas can affect functioning at any age, no mention has been made of the kind of degenerative changes that are associated with advancing age. He felt that any analyst would take steps [if] they were aware of a significant problem; the problem is if they are not aware of it. The current system protects individuals by not singling them out specially on the basis of a disability. We should not dismiss this problem. The question we need to ask ourselves is, is there a better system? If so, let's try it; if not, let's not throw out the old system [p. 3].

All that is required at this point is to add that the motion to drop all reviews and procedures based upon age was passed. At least for

now, age is not a factor at The Michigan Institute. There is only one report I know of in the literature that deals with issues relating to either having or not having a specific retirement policy for training analysts, and that was reported by Michaels and Schoenberg (1966) based on their deliberations as part of a committee of the Boston Psychoanalytic Institute. As their training analysts aged there arose an occasional necessity to consider the voluntary or nonvoluntary retirement of an analyst whose functioning was now impaired. They were able to agree that this painful but necessary chore could best be handled by instituting a detailed policy in regard to retirement. In essence (p. 214), 68 was selected as the cut-off date after which one could not accept new candidates for a training analysis although they could continue to supervise and teach until the age of 70. Provisions were made for exceptions that could allow supervision to continue after age 70. On the other hand, although the Board of Professional Standards of the American Psychoanalytic Association had requested its Committee on Institutes (1971) on two different occasions, 1964 and again in 1969, to provide it with general guidelines for retirement it might then pass on to the constituent institutes, it was unable to do so. On both occasions the sticking point was the intense opposition stirred up by what was felt to be "the arbitrary nature of guidelines based on age" (p. 5). This may have been all the more surprising because of the twenty-one Institutes who had provided the subcommittee data for their poll and had a definite retirement policy, by far the majority had opted for fixed policies for retirement based on age (14) and only a small minority (5) preferred policies where a retirement was not based on age. So once again, Freud (1915) may have been right when he said, "at bottom no one believes in his own death, or, to put the same thing in another way, that in the unconscious every one of us is convinced of his own immortality" (p. 289).

If we praise him for what he said, we may have only questions and speculations about what he didn't say. I am referring here to his thunderous silence on the issue of the numerous countertransference reactions that must affect the chronically ailing or dying analyst and the special technical problems this poses in best serving a patient's needs at such times, especially since he suffered from a cancer of his mouth for his last sixteen years that left him with symptoms that must have been apparent to his patients. But if any blame is to be assessed, we must all share in it, with a few notable exceptions. I know of only two papers (Halpert, 1982; Eissler, 1977) and, most recently, only one

book (Schwartz and Silver, 1990) in the literature that devote any time to the issues faced by the dying analyst with specific suggestions of a technical nature being made. These authors recommend that where the analyst knows he or she is dying or will not be able to work much longer, these facts should be presented to the patients to give them a chance to deal with their reactions (and especially their anger over being abandoned) before referring them on to a colleague—while the original analyst is still alive.

It is unfortunate that there is no space to discuss these works and two others that also impinge on our topic. I am referring here to the personal and technical problems posed for both the analyst and the patient, when the analyst, regardless of age, suffers from an illness that interrupts the analytic work for an extended period. We can only admire the courage and honesty of both Dewald (1982) and Abend (1982), as well as the professional competence and sensitivity they showed in exploring the countertransference reactions they had to cope with in relation to illness. They also shared with us their individual solutions to the technical dilemmas involved and perhaps more important, the rationale by which they arrived at them. Even in those areas where the author found himself differing with their conclusions, or solutions, it was always a respectful difference.

This brings me to the final dividend I earned as a result of this labor. Training analysts and teachers have not included in our curricula the array of subjects relating to aging and its termination. Most institutes of the American Psychoanalytic Association do require of their graduates that they get some supervision during the termination phase of their work with a patient, but none that I know of requires any special knowledge of, or plans for, our own termination and the problems that precede it. It is my hope that some day every institute will see fit to do this, along with encouraging the establishment of ongoing study groups available to all graduates, of any age.

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13

A Psychiatrist Looks at His Own Aging

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The thrust of this essay will be that the biological processes of growth and aging are paralleled throughout the life course by the psychological processes of development. During the older years, biological process accounts more for aging than for growth, and commonly results in decline and loss of function. Nevertheless, such change can be a major stimulus for new development in compensation for the loss associated with aging. The developmental process facilitates our dealing with problems of the older years as it has in the preceding years (Settlage, Curtis, Lozoff, Lozoff, Silberschatz, and Simburg, 1988).

I intend to approach this complex subject by discussing some of my reactions to my own aging. Following on this I will discuss some of my reactions to the aging of people who are close to me personally, and to people with whom I work professionally. Portions of this essay necessarily will be autobiographical. My discussion will be moving from self to object and object to self. For older years I am using the time frame of 65 and beyond, with special attention to the first decade after 65. This happens to coincide roughly with my past ten years (I was born in the Spring of 1915). For the term *elderly* I will be emphasizing experiences of persons in their eighties or older. Though I am using specific ages, I am following the general classification of middle age, later age, and older later age (Greenspan and Pollock, 1981).

The popular use of the term *aging* means getting old and it often implies becoming impaired. Some physicians perpetuate this usage by telling a given patient that he need not be concerned about his ailment but rather he should expect it since after all he is "getting

older." I want my physician to spell out what my impairment is and what is the specific pathology. Whenever I can I encourage my patients to request this information from their physicians. Getting old is not a diagnosis, and when offered as a commentary it becomes nothing more than a negative value judgment.

Sophocles wrote *Oedipus Rex* at age 75. He won drama prizes at age 85 and wrote *Oedipus at Colonus* at age 89. He died at age 90. I grant this is unusual creativity in the later years but not exceptional. Creativity in the older later age is found in writers, artists, and musicians, and their contributions have been detailed by many who have become interested in the later years. Even more interesting to me is the active healthy person who continues to enjoy living virtually to the end of his or her life. These successful people are the ones who prompted some of us to form a study group and to try to learn something about their development (Settlage et al., 1988).

Supporting the developmental approach to the understanding of aging are writers such as Morton Shane (1977), Colarusso and Nemiroff (1979), and George Pollock (1980). Shane wrote "that the developmental approach implies that the analytic patient regardless of age, is considered still to be in the process of development as opposed to merely being in possession of a past that influences his conscious and unconscious life" (pp. 95–108). In their theory of adult development paper Colarusso and Nemiroff wrote how "exchanges between organism and environment occur from birth to death producing a continuous effect on psychic development" (pp. 59–71). Pollock (1980) has provided us with the concept of mourning-liberation. With this phrase he reminds us of our grieving for diminished or lost functions, and at the same time our being freed to develop new interests and new functions.

I owe Pearl King (1974, 1978) my gratitude for her stimulating papers. She encouraged us to work with the older patient as we would with any of our adult patients, and to apply our usual criteria for suitability for analytic work. I have been able to confirm for myself that age alone is no determinant of the suitability for adult analytic work (Simburg, 1985). I like Abraham's (1919) dictum that the age of the neurosis is more significant than the age of the patient in evaluating suitability for psychoanalysis.

The leadership of the group in Boston with Dr. Martin Berezin and Dr. Ralph Kahana has been very encouraging for therapeutic work with the elderly. Drs. Stanley Cath and George Pollock have

encouraged me directly and personally to participate in panels and to publish in this field. Locally I have led two colloquia for professors and graduate students entitled "Psychoanalytic Perspectives of Adult Development."

I have developed a special interest in working with older patients and I have joined psychiatric and psychoanalytic colleagues in pursuing this interest. I had had *no* expectation that this would become a special interest of mine. I remember well as a resident at Yale (1941–1943) how surprised I was to have an elderly couple (early seventies) consult with me, and then to hear the wife say that she was frustrated and unsatisfied sexually. Her husband appeared to have lost his past enthusiasm. Even though still potent he had become more and more passive.

Today I am much more aware of gender shifts in aging. I know how often the woman appears to be more aggressive than she had been and to provide leadership more openly than she had in her younger years. Often the man appears to have become less aggressive and sometimes even passive. It takes careful work to determine conflicts and their basis. I appreciate that sex is an ongoing enjoyment, and that there are problems in the older years as there are at any level of development. At times what had been of concern about parental disapproval in the early years may be experienced as concern about adult children's disapproval in these later years. This transference reaction can be a problem for some older couples.

Generally I find work with the elderly to be an enjoyable experience. My patients are strongly motivated to promote change in themselves. They tend to be reflective and to respond with insight to interpretations. Just recently a patient in treatment was talking about how when she and her husband were young parents, her husband had been distant from their children. From her associations I was able to point out to her that her husband showed possessive jealousy and that he wanted her for himself. She began to laugh and said, "Only yesterday he was telling me you don't have to go to the doctor. You can stay home and talk to me." This kind of ready association with a quick confirmation or contradiction of my impression when offered is a frequent experience in working with the older patient.

Despite all the positives which I have mentioned, more often than not the older patient arrives for treatment with serious doubts about the practicality of seeking treatment. Usually this is expressed in terms of misgivings about her capacities. When convinced of the desirability

of some internal change the patient may say, "I am afraid I am too late" or "Probably it is too difficult or will be too difficult for me to change." Often in the flush of early transference reactions the patient may say, "I wish I had met you many years ago" or "I should have come to see you many years ago."

Occasionally the resistance to treatment is presented as the attitude of a spouse or of one of the adult children. Even when the family member is portrayed realistically it still may provide the patient with a convenient reality onto which she can place and conceal her own opposition. Dealing with ambivalence as an interpersonal rather than an intrapersonal conflict is not rare at any age, but I have been made aware of the frequency of this defense in the older patient. Further I have been impressed that the older patient is accommodating enough most often to begin analyzing this defense. She clarifies her self image by differentiating what is her individual self from previous blurred images involving self and spouse or some revived child self and adult images.

The issue of aging appears at all levels of development. Accordingly it can appear in the treatment of patients at any age. Common markers both biological and cultural may appear in patients' productions at any time. These references have to be understood in terms of the patients' reality, and just what meaning these may have in the patient's treatment at the particular moment when they are presented. The younger woman who starts thinking of the time left for her to have a baby and the younger man who has a definite financial goal which he is to attain in the time left before the age of 40 are common examples.

These time-limiting concerns are not the language of the elderly; either such goal was attained or altered. Generally the elderly tend to be less driven in their considerations of time left. Often they would like to enjoy their life remaining with family and friends. The idea of becoming a burden is a dreaded concern for many. Accordingly physical and economic health can be major issues. Mental health is talked about in terms of functioning. Alzheimer's disease has become the term for senility—as well as any possible impairment of cognitive function. Depression is a common diagnosis, and at times it is self-diagnosed with some realistic awareness. Inevitable death may appear to pose a smaller threat than do impairments.

While death is accepted as part of living, often the loss of peers is experienced very painfully. In addition to the usual dynamics of

mourning, loss of peers marks the decreasing social circle for many. While it is true that some people are always making new friends and often friends of all ages, also it is true that some people rationalize their social passivity by blaming their age. In analyzing their anxiety often it becomes clear to the patient that initiating or reaching out has been conflictual long before she could claim old age. Dependence–independence conflicts become more meaningful when traced back to their beginnings.

In reflecting on how I have been experiencing my own aging I realize that one of my reactions is a sense of continuity with my past, even when I become aware of changes. Genetically I have been endowed so that I look younger than my chronological age. Friends will comment on how I have looked the same for at least the past ten years. In many ways I feel the same as I have felt and experience some sense of harmony between internal state and external appearance. Nevertheless I am conscious of certain changes.

I feel more leisurely about my usual activities. There is a change in the pace at which I move, and the manner in which I do things. I seem to have more time to notice details about people, and details about my environment. I have experienced a subtle change in my orientation to my wife. I am more ready to empathize with some of her feelings including some of her complaints. Even when I do not agree with her, particularly when I am the object of her complaint, I can realize more readily the basis for her complaint. Though it is not invariable this increased empathy seems to be part of an increased sensitivity to the other person. I notice this increased sensitivity with patients and with friends, as well as with my wife.

Our mutual dependencies are becoming more evident to me. I am much more conscious of how much I rely upon my wife. I am sure I relied upon her every bit as much a decade ago, and perhaps she depended upon me at least as much as she does now. I realize better now how and when she wants more leadership from me. Because I want her to know, I have become more active in ensuring that she knows the details of our finances, insurance, and taxes. Our wills are no longer something that we had prepared and reviewed a decade ago. Now they have acquired immediacy for updating.

Our ambivalent feelings about being classified as seniors are diminishing and we do accept ourselves as older citizens in our community. I remember well when I was first called "Sir." It took me a while to connect this title with myself. It took me yet more time to settle in

with it, and to accept it as part of my self-image. The title doctor involved the same process of adaptation, plus some very special excitement connected with my sense of achievement through my own efforts. Doctor continues as my primary professional identification. Psychiatry is my medical specialty, and psychoanalysis has to do with the way I think and practice in my specialty. All of these involve self-image shifts while maintaining a continuity of self representation.

When I became a father and later was called Dad I felt a different pride, and a new status (I have three children and four grandchildren). Also I felt the audacious sense of pleasure on being on par with my own father whom I called Dad. The oedipal issues were intuited only, since my own analysis was still some four years away following the birth of my first child. Granddad is a title I wear with pleasure, and the settling in process seemed to take much less time. Nevertheless it motivated me to do some self analysis and self reanalysis. Mining it for oedipal components has been comparatively easy. Appreciating the parent–child relationships, and identifying with each person in the three-generation relationships has been illuminating. Since I had a granddad the total investigation has involved five generations. This item I have met in analyzing older patients who are grandparents (Simburg, 1985). It is impressive how easily my patients can move to and through any one of the five identifications and because of my own work it has become familiar.

Challenges to my grandfather never had the intensity which I felt with my father. Challenges from my grandchildren never provoke the tension or the anxieties which I felt with my own children. My grandmother was idealized and I realize now how convenient she was for splitting the ambivalent feelings I had for my mother.

At the present time I am working with a man who treasures his visits with his grandmother and who feels strongly negative about his mother. It has not been to difficult to help him see how he diverted his affectionate feeling from his mother to his grandmother and concentrated hostile feelings on his mother, even though some were initially directed toward grandmother. Earlier he had used his father in much the way he uses his grandmother now.

One of the gratifications of these older years is to be able to feel familiar with what my patient is talking about; to be able to sense how he is experiencing what he is talking about, and to be able to compare and contrast his experiences and his way of reacting with my own.

Identifying with any of the generations involved, or any developmental levels presented, enables me to empathize with my patient wherever he may be, and in addition to learn from each patient the uniqueness of his way of experiencing. I am more confident about distinguishing realistic perception from transference and countertransference reactions. This increased confidence extends to social interactions as well as the professional. I am more trusting of my perceptions, and my recognition of my own transference reaction to a friend than I had been in my younger years. When I talk of friends I include the best friend I have, namely my wife Virginia (born in the winter of 1917).

Without any warning some three years ago Virginia developed a respiratory condition. Ever since she has been battling energetically to effect some reversal, and we hope a cure. Her determination, and her exceptional cooperation with her physicians, has evoked their admiration, as well as mine. She has always been well organized and very practical. Now I am more aware of these qualities, and also more appreciative. She continues her routines, which include taking care of our home, garden, and feeding us well. Also she manages our social calendar for entertainment and recreation. Despite medications and time-consuming use of bronchodilators, she manages to have our schedule such that we continue to live much as we have been living for the past decade. She has made one concession—and that is to entertain smaller numbers of guests at dinner. Also we dine out with another couple on occasion rather than entertain them in our home along with some other guests. Happily some of our friends like this and are following suit.

One serious change is that Virginia is grounded for long flights. Her range has been reduced to two-hour flights or less. This is because of recurrent infection following flights, with exacerbation of the respiratory difficulties. Cigarette smoke and the poorly recirculated air are the hazards of flight for patients with respiratory problems. Virginia is quite uncomplaining. Nevertheless a medical condition which could become chronic affects everyone involved. There are side effects from medication which change her appearance. Now she has early cataracts which affect her vision. Both of us have to accept this and adapt. Fatigue is inevitable and so generally she has slowed to three-quarters time. Her continuing interest and her initiative resulted in our taking lessons in ballroom dancing over the past two years. Though we had considered ourselves to be fair dancers it is only now that I appreciate

some of the responsibilities of leading. Before, I simply expected the woman to adapt to my lead. Now I realize I have to help her to follow my lead by signaling to her what it is I will be doing from moment to moment. I take it as a parable for my responsibilities in my marriage. I realize that my wife is entitled to sufficient notice concerning any of my plans and pleasures.

About fifteen years ago sudden painless hematuria suggested the possibility that I had bladder cancer. My urologist found a congenital bladder diverticulum with a malignant area in the center. He excised the diverticulum and the cancer proved to be stage 1 or 2. Vigorous after care has prevented any recurrence thus far. Monitoring continues.

In 1980 routine chest films showed a 10-cent size area in my right lung that was suspicious. I felt sufficient anxiety in association with the suspicion. After many X-rays and pulmonary consults the chest surgeon decided on a lobectomy. With his decision he relieved me of uncertainty about treatment and made clear his conviction of lung cancer. This was followed by radiation. One lymph gland showed adenocarcinoma as did the primary. I was very relieved by the good treatment results and the favorable prognosis.

The conclusion was that I had developed a scar tumor in the area where I had had pneumonia in childhood. Even here I have some sense of continuity. I monitor my lung functioning and when last year I developed postinfluenzal pleuropericardial effusion there was much checking about my lung functions with continuing concern about possible further malignancy or tuberculosis. Throughout the investigations and treatments I have been able to continue seeing my patients without any unusual interruptions of our schedules.

One patient knows of my chest surgery and the reasons for it. She has feared abandonment since early childhood and I have assured her that I would keep her apprised of my health status. She would have full and early information should I have to discontinue our work. Another patient knows from hospital sources that I have been an inpatient without her knowing the specifics.

With the bladder surgery medical colleagues who would see me exercising on the ward simply assumed that I had had a prostatectomy. Interesting how readily this is taken as a milestone in aging. A transurethral resection (TUR) is looked upon by many as a sign of aging, and by some as the reason for diminished libido. I have accepted my own diminution of the past two years after initial surprise

and disbelief. Gradually I have come to accept this as a slowing of my sexual pace. My partner was philosophical about my altered pace even before I reconciled myself to it.

This altered pace is evident to me in everything I do. I work the same number of hours in practice, yet I do so in more leisurely fashion. Special projects will motivate me to exert some extra effort but these are time limited. In my practice or at meetings, as well as at home or on the tennis court, my perspective has changed progressively. I feel good about winning the tennis game but I have sufficient pleasure in making the shot I had planned, or succeeding in blocking the shot of my opponent. The timely interpretation is still a conscious goal in my professional work, but the ongoing relationship with the patient has been gaining in importance. In all that I do or think of doing I sense I am more patient than I had been. I can expect my wife to disagree both about leisure and patience, and I can accept that too.

How have these experiences of mine affected my perspective on aging? In general I think of myself as more empathic than I had been before. I can identify more rapidly with some of the complaints and many of the concerns of my older patients. However, empathy is not restricted to age peers. My generalization is that I see myself more empathic with any of my patients irrespective of their chronological age. I am more sympathetic than I had been earlier in my career and I am more open about expressing sympathy and offering emotional support. I am less guarded about my patient becoming aware of my own personality characteristics, or at times some details of my personal history.

There are times when a direct question from my patient deserves an answer, and I can do this without sacrificing opportunities to learn the meanings of the question to the patient, and to me. More and more I am conscious of the two-person relationship in our work. The dyad involves transference reactions from the patient to the real person the analyst. To differentiate what is transference from what is realistic perception the analyst person has to be real and can be subject to discussion in any and all of the interactions. Not always is the patient attempting a role reversal.

My reactions to the patient have to be distinguished from my realistic perceptions of the patient. My countertransference requires the same careful attention that the patient's transference requires. While it is true that I am working with a patient who is in analysis, it

is equally true that the analysis involves an interaction between two persons and not the investigation of the analysand as if in isolation. Consequently, I am more free than I had been to speak of a prejudice or bias of mine and how I try to make allowance for it. Significantly I find more bias for or prejudice in favor of the patient than I remember experiencing in the past. More often I experience myself as an advocate for the patient. This can mean intervening against a patient's unreasonable demands on himself. This is not evenly hovering attention and this is not neutrality.

Over the past few years I have been involved actively in a workshop where we meet monthly to discuss adult development. As a result of these discussions we have published a paper "Conceptualizing Adult Development" (Settlage et al., 1988) and now we are attempting to clarify our understanding of both developmental and therapeutic process. I was invited to join this group because my interest in the older adult had become known in the psychoanalytic community (Panel, 1979).

I had been treating a depressed woman who came to see me in her late sixties. She experienced some lessening of her obvious anxieties and some lifting of her depressive mood. We continued to work together on the reduced program. I saw her weekly and was available to her in the hospital whenever she required some hospital care. She had a pacemaker, some orthopedic problems, and some problems with diverticulosis. When the latter became diverticulitis her surgeon welcomed my availability both for pre- and postop consultation and ongoing care. This patient continued her program of psychotherapy until her death in her early nineties. Part of our work was in anticipation of her death and having her express her feelings about her death. How she was planning to distribute her possessions to her children and her grandchildren illuminated these relationships.

Working with a patient who is anticipating death can occur at any age. I have seen a few such people in their middle years but most patients have been in their later years and often because of a malignancy. A patient from New York City while visiting in our community developed hip pain and was diagnosed as suffering from multiple myeloma. I was called in consultation by the oncologist and had the satisfaction of helping the patient accept the reality of his diagnosis and the reality of his feelings about his diagnosis. Accordingly he accepted referral to a colleague in New York City and continued to work with this psychoanalyst in preparation for his death. On

his return to New York City he wrote several letters keeping me informed. They were impressively cheerful.

The changes in my understanding of the older and late older person were stimulated further by discussions in our study group. These have contributed to the changing attitude I experience in my practice. I enjoy my work in psychoanalysis and in intensive psychotherapy more now than I remember experiencing in the past. In my paper "Psychoanalysis of the Older Patient" (Simburg, 1985) I compare my feelings on first analyzing the older person to the excitement and to the pleasure of working with my first analytic patients (supervised cases).

Today, my experience is more a steady satisfaction. I have fewer alternations of excitement one day, and doubts and misgivings the next. I have a growing appreciation of the psychoanalytic process and an increasing respect for everything the patient is communicating both verbally and nonverbally. Together with this I have a realistic awareness of my own fallibility and how often the patient may help me to correct my own mistakes.

Not all people seeking help are patients. Occasionally there are friends and neighbors and even colleagues. Some volunteer their concerns about an aging parent. There are families where continuing development is expected and good health is the daily experience. If aging is considered it seems to be mostly a statistical item. These are families where longevity is the endowment and activity, both mental and physical, is the cultural norm. These are the beautiful people who continue to contribute in their fields of special interest and to the communities in which they reside. Our study group has been paying special attention to what we can learn about the development of these admirable people.

This past week I had the opportunity to interview a physician who will be 100 years of age this year. A fall down a flight of stairs in 1987 resulted in enough damage to persuade him to retire fully from his practice of internal medicine. Both he and his patients were saddened by this. He continued to come to various programs for our hospital medical staff. He attended tumor boards and any other such programs which might interest him. He had always been an active person and keenly interested in using his body. He hiked, he swam, he played tennis, and he was an avid skier. He offered these physical activities as interests which contributed to his healthy longevity. While

accepting this I tend to credit the keen quality of his interest in whatever he did as contributing significantly. This includes his passion for his family members and for his practice of medicine.

We are honoring him because he represents the exception. He is approaching the century mark and so he has achieved the unusual longevity for which we assume a significant genetic endowment. Also he demonstrates the continuation of his functions both mental and physical to a high degree of effectiveness. This we admire both because it is the ideal we seek and because he has achieved it. In this same week a retired physician died at age 103. With him only longevity was emphasized. By contrast the honoree showing continuing development is feted.

Many people have lesser expectations and less active approaches to aging. Some people worry about their old age and often this proves to be a worry about who will take care of them. For many the image of aging is that of progressive if not rapid deterioration of all functions. Retirement is a goal and often the younger their chronological age the better. For these people retirement is reward time for the hard work of the job or of raising a family. The reward is relished for many years in advance and talked about as trips to be taken and relatives—children and grandchildren—to be visited. For many there is more and more withdrawal from activities both mental and physical. The retiree tends to become more and more the spectator and less and less the participant. Such traits are present early and with the passing years they are revealed more and more clearly.

When I am consulted even informally I have to concern myself to what extent my credo may differ from that of my neighbors and friends. Recently a friend of many years asked me how to deal with her husband of around 80 years of age who seemed a bit hypochondriacal and was developing more and more dependence on her. She did not want to appear unsympathetic but at the same time she did not want to encourage his increasing dependency. Though we had known each other for years, this was the first time that she consulted me about anything. I did not delve into the timing of her request as I would in a formal consultation. I accepted how serious this was to her. I suggested that she would help enormously by being her usual known self and not try to play any roles. I assured her that by her being constant and consistent her husband would be able to feel more secure because she would remain the known and the familiar person. In turn this would help him to resume his previous more independent

functioning. She seemed happy to relinquish the role-playing idea. About one week later she died quietly in her sleep. Her family talked lovingly of her peaceful death, and how her death was so much like her.

Another friend was hospitalized several times and on this admission he asked his physician whether he was becoming terminal. According to his report his physician told him it was no longer a question of becoming since he was in fact terminal. Irrespective of the actual conversation my friend was shocked. Despite his surgeries and repeated hospitalizations it became clear that he had not expected to die for some time. He was in his eighties as was his wife, but she was the one who had been more ill and he was her support. Included in the shock about his dying was the unexpected precedence over his wife and his concern about her knowing how to manage on her own. My visits involved frank discussions about his dying and how he was experiencing this prospect. He cried freely and accepted my emphasis on quality of life as contrasted with length of life. Also, I was in the position to assure him that his wife was concerned that his death be peaceful. This was her priority. She faced her future confident about managing on her own and very much aware of how much she would miss him.

Throughout my visits my friend identified me as his friend who is a physician, and who happens to be a psychiatrist practicing psychoanalysis or intensive psychotherapy. At no time was there a formal consultation. I was his friend who came to see him because I cared about him. It occurs to me that at times in actual consultation with a patient who is terminally ill I begin to develop feelings for my patient which approximate such feelings of friendship. Where we can work together sufficiently the depth of feeling experienced promotes the sense of knowing each other better and caring sincerely.

In 1988 I had the pleasure of attending our 50th Medical School Class Reunion at McGill. Also I was invited into the membership of the Senior Physicians Association. In some circles I have been viewed as a senior physician long before this. Often I am one of the oldest persons present at the meeting, and at times I may be one of the most experienced scientifically or organizationally. Only now am I sensing that colleagues are beginning to think of me as one of the active old ones. It is true that when one of them speaks of the old times and mentions the 1960s I have thoughts of the late 1930s and 1940s.

So what about my retirement? When I force myself to think seriously about it I realize that I am approaching this as something for which I must prepare myself in advance since it holds no appeal for me at present. I am thinking of some period in my eighties as the probable time. I am assuming that part of my preparation will involve further slowing of my pace while continuing my work with patients at an intensive level. I hope to acquire added qualifications to my boards to enable me to identify myself still further as especially qualified to work with the elderly. I expect to continue my present interests in the terminally ill, and in the problems of some of the caregivers. Earlier interests such as those in adoption, oncological psychiatry, and consultation liaison, remain. The next decade is bound to bring some developments in psychoanalysis and in psychiatry which I am not yet able to predict but which I am sure will be of interest. I expect to give them all the attention that I can muster. Also I believe that demand for adult psychoanalysis will continue and that there may be some increase in interest at all age levels.

Accordingly it is my responsibility to explore all aspects of the retirement question as I experience it for myself. I have taken the position (Simburg, 1985) that age alone is not the criterion to determine the suitability of a patient for psychoanalysis. I am saying that the same applies equally to the other member of the dyad. Age alone is not the determinant of the suitability of the analyst to do analysis. Interestingly enough when Freud (1905) was declaiming on the limitations of persons about age 50 for psychoanalysis he was then aged 49. He made no reference to the suitability of the analyst of that age or beyond to do analytic work.

In addition to my self observations I have the insurance of my perceptive wife who has brought me down to earth many times. Virginia lets me know quickly and deftly whenever I am functioning at what she perceives to be "different from your usual." In addition I know that my patients have shown me some sensitive reactions to any alteration in my health status. I can expect them to let me know about decreases in my efficiency while working with them. Finally, I am satisfied that if retirement should become a conflictual business of some proportions I will apply to a colleague for some more analysis (nachanalysis).

A colleague who is about 78 years of age has removed his age from our County Medical Association Directory. He told us that one day a physician who came to him for treatment told him that he, the

patient, had looked him up in the directory and when he saw the analyst's age he became worried that this analyst wouldn't be around long enough to enable him to complete his analysis. Age is a convenient reality for this patient to use in constructing his abandonment fantasy. My inclination is to emphasize another reality, namely that every analysand takes some risk with any analyst of any age. There is no guarantee that the analyst will live long enough or remain well enough to help the patient complete his analysis. Where there are dates certain for retirement or relocation a new patient seeking analysis can be referred to a colleague who is planning to be available in the community for an indefinite period of time.

How we deal with losses is something with which we can concern ourselves to our own advantage. Development throughout the life course involves relinquishing certain gratifications for newer and at times more distant satisfactions. Generally our losses involve persons and things. The loss of persons is the more painful, and usually for the elderly the loss of parents has been mourned, and new attachments have been established. The loss of children can be quite traumatic, especially where there has been little preparation. One patient consulted me for analysis after the second of her adult children committed suicide. Another patient in analysis had to deal with the suicide of an adult child. As can be expected guilt is a significant reaction in the total grieving experience of the older adult, even when the guilt is identified as irrational.

The loss of function is another reality with which the older adult must contend. Losses of visual or auditory capabilities are painful and there is grieving. However, losses of sharpness in cognitive functioning are dreaded. Becoming forgetful when it is slight can still be handled with humor, but where it begins to affect orientation for time and place as well as person there is no longer much in the way of humor. Death is a welcome alternative to degeneration requiring custodial care. Our nursing homes are in the main shameful places, and their inhabitants often persons who have lost their personhood. The vegetative state appears to be a tragic prolongation of life in a person who is no longer alive but is still living. There is no question in my mind that such a person is a loss to himself and to his survivors. I believe that most ethics committees favor a do not code or do not revive position. Fortunately such patients represent very few persons in the total population of the frail elderly. Our senile patients represent no more than 5 percent of the total population of elderly people (U.S. Senate Special Committee on Aging, 1987–1988).

I accept the reality of my death together with the sense of loss of self and of others. In many ways losses experienced throughout the course of my life have prepared me to accept my losses realistically. In some ways I experienced each loss as a prologue to new and different ventures. When I was sent to the city at age 9 to learn Hebrew I was boarded in the home of my parents' friends. I suffered the loss of my parents and my friends as well as the pleasures of my native small country town. In my analysis I learned how deeply I felt the pain of separation from my own family and how much of this I had repressed.

I had to learn to get along in a different family. It was a family of boys who treated me well enough but their ambivalence showed through with hazing and bullying. I realize now that my competitive position was to do as well as they did and when possible to beat them athletically and academically. At the same time this resulted in good reports to my family back home. Also I had the feeling of living with siblings, and the realization that as important as my parents were I could survive under the supervision of these "foster" parents. Nevertheless when reunited two years later I was very happy to be with my own family.

I learned that survival was not guaranteed. A classmate of mine was killed accidentally at the age of 8 while serving as bat boy for our local baseball team. My paternal grandparents died in succession a few years after they had arrived from the "old country." I had idealized my grandmother, and was in awe of my stern grandfather. They were convenient for splitting my ambivalent feelings for each of my parents more directly. I realize now I had done a fair amount of splitting until I had resolved my continuing oedipal conflicts. The deaths of my father's brother and my mother's sister in the 1930s made it necessary for me to deal with my parents' mortality, even though I was not fully conscious of my fear of losing them at that time. I remember feeling sympathy for each of them, yet it was still more their loss than mine. When they did die in this past decade I was well prepared for our parting.

My graduate medical training involved relinquishing my plans to be an internist because training in psychiatry was not organized as a supplement to internal medicine. For a brief period I experienced some sense of loss until I became fascinated with the prospect of helping patients with their emotional problems and not just diagnosing them. To accomplish the latter I went after psychoanalytic training, and even now I can experience both excitement and pleasure

when the patient and I gain some understanding of the meaning of whatever has been obscure to both of us. What seems to help is that we are sharing in the discovery of these meanings and in the pleasure experienced in doing so.

My interest in internal medicine is not lost. I attend programs in continuing education in our hospital and I serve on a number of medical staff committees. I am on the committees for cancer, continuing education, ethics, consultation liaison, and impaired physicians to name just a few. Geriatric psychiatry helps further to keep me informed about the various branches of medicine. Before deciding on medicine as an undergraduate I had some vague notions about philosophy. I realize more and more that the philosophy associated with understanding people is at the very center of my professional interests. In medical school I was proficient in neurology. My interest in clinical neurology continues and some of my patients refresh this interest. And so it is that I experience continuity and change together.

The prospect of my death involves the ultimate change and has required realistic preparation. Virginia and I have signed our durable power of attorney forms. We are assured that our living wills will be respected. The means of death is now more important than the fact of death. What survives one or both of us has been considered and for this we have done the practical things. There are always the personality preferences. Just a few weeks ago Virginia said that if there is to be a memorial service for her or for me she would like it to take place in our home with just a few people. I concurred and admired her foresight.

My own more narcissistic orientation is reflected in an honor which I received this year. I am reproducing the announcement which appeared in the medical staff newsletter of September/October 1989.* I am delighted to have this recognition and to have it while I can still enjoy it rather than to have it planned as a memorial. As is evident from the announcement my interest is in the direction of

*SIMBURG LECTURESHIP ESTABLISHED

The Alta Bates-Herrick Foundation is pleased to announce the establishment of the EARL J. SIMBURG LECTURESHIP upon the receipt of an anonymous gift of $10,000. The purpose of the Lectureship will be to provide an honorarium to a distinguished lecturer for an annual lecture on recent developments in psychoanalysis. The Simburg Lecture will be presented to the health care professional and mental health communities, as well as the community-at-large.

The Continuing Medical Education Committee of the Alta Bates-Herrick Hospital Medical Staff will be responsible for the selection of the lecturer in consultation with Dr. Simburg.

ongoing education and especially in the field of psychoanalysis. I look forward to helping increase awareness and understanding of the use of psychoanalysis in all fields of medicine and not just psychiatry. I look forward to learning about developments within psychoanalysis, and with George Engel (1975) to promote the realization that "Psychoanalysis is Alive and Well."

DISCUSSION

By using myself as the person under observation I have revealed some of the changes I have realized in myself during the past decade. The past decade is convenient for my own biography and is a time frame for these observations. I think of these changes as coming about through the process of development. I regard the changes as coming about unconsciously and having an indefinite beginning. I have become more and more conscious of these changes as I have worked with older patients.

Continuity and change could represent one of the themes of my self-observation. I have detailed personality changes such as increased tolerance for differences with significant people. The people include patients, personal friends, and relatives. Also I have detailed some changed attitudes in my working relationships with patients in analysis. I am oriented more and more toward the team concept of psychoanalysis. The dyad is a two-person process in which each makes a continuing contribution and in which each reacts with feelings. The patient's feelings are available for analysis. The analyst must pay equal attention to his own feelings. I believe I have increased my awareness of my own feelings in a given analytic situation and that I am better prepared to identify and deal with my countertransference reactions. I respect my patients' perceptions about me more readily than I did before.

My observations on myself as I provided biographic material are interwoven with my analytic awareness and understanding. I tried to differentiate autobiography from what could have become a report on a self analysis. At times the associations were such as to bring memories from early childhood into continuity with adult experiences right up to the present. An example of such is the reference to losses and my reactions to these.

Certain topics are deserving of extensive discussion but space constraints made it necessary to make only a brief reference or omit them altogether. These include sociologic issues such as prejudice against the elderly, against aging, and against psychoanalysis both for therapy and for psychological theory. The quest for eternal youth and the wish for immortality may have some kinship. The problems for adult children who are concerned about their aging parents is an important topic. The problems for retirees belong in any discussion about aging in our culture. I touched briefly on my own awareness of conflict about my own retirement. The bashing of elderly or the molesting of elderly belongs in any discussion of prejudice about aging. The growing political power of organized older citizens can be an extension of any such discussions.

A more severe criticism of this chapter could be that I present my material with optimism sufficient to raise questions about how realistic is my view of the elderly and how familiar am I with the frail elderly. I am fortunate in my endowments and in the good outcomes of serious illnesses suffered both by me and by my wife. Further, our relationship may appear to be too benign. Let me hurry to assure the possible critic that Virginia and I have our differences and certainly our arguments. If there appears to be an imbalance I offer the correction that we can and do criticize each other. Fortunately these are expressed and reconciliations follow in a reasonable period of time.

Finally I do have an objective and that is to help promote a more positive attitude toward our own aging and our treatment of the elderly. I believe that our experiences both with our patients and with ourselves provide us with data powerful enough to counteract some of the negative attitudes in our society about older adults.

CONCLUSION

Aging and development continue throughout the life course. Old or older age can be a time for enjoyment of self and others. Hitherto aging has had a bad press because an inordinate emphasis has been placed on the tragic experiences of the seriously ill. The small percentage of older people who require constant care has been taken by many to represent the inevitability of the aging process. I disagree with this and I believe we have a responsibility to correct erroneous beliefs. Where prejudice against older adults is found to derive from

anxieties about isolation and about dependence, as well as other feeling states, it should be exposed as such. In our work with our patients and in our discussions in the medical and larger communities we can do much to turn negative anticipations about aging into more realistic and pleasurable experiences.

In discussing my own aging I have identified changes taking place in me while I maintain my sense of continuity of self. I experience these changes as favorable and as part of my continuing development in these older years. These changes represent newer and to me better integrations resulting in turn in what I regard as improved functioning. I look forward to continuing development for the rest of my life. I see it in many of my older friends and in a high percentage of my patients.

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14

The Joys and Sorrows of Aging

Roy M. Whitman, M.D.

My knowledge of aging comes from six sources: (1) my father, mother, grandfather, and grandmother; (2) my patients; (3) myself; (4) my reading; (5) my sibling; and (6) stories and jokes.

MY PARENTS AND GRANDPARENTS

My father quickly grew old when he retired from an active dental practice and moved from Manhattan to Long Beach. He spoke constantly of returning to his practice, but my mother out of his vision would always shake her head. Then he developed carcinoma of the prostate, which metastasized to his brain. He became blind, and the last year and a half of his life he lay in a bed in their retirement apartment house and carried on desultory conversations with visitors. We tended to speak over and around him, but every now and then he would rouse himself and speak quite accurately and to the point. Since his hearing was almost gone as well as his sight, we tended to pay little attention to him, but nevertheless he once said to me quite bitterly (but also humorously), "What kind of a visit is this for a Jewish boy to pay to his father when he only stays a day or two and hardly speaks to him?" I was startled, touched, and laughed. I paid more attention to him after that.

He had a terrible temper which could be touched off at the most minor of provocations. While the family good-naturedly put up with this character flaw, the retirement building's gentlemen would not,

and he was often overlooked at the evening card games, since his presence often led to rows. This hurt him deeply, my mother more, since it prevented them from settling into the pleasant retirement life they had envisioned. He died of a stroke at age 79 and I felt little grief. His mother had died when he was 13, and my mother had taken a surrogate role as his mother, and he often competed with my brother and me for her affection.

My mother gained new strength after his death in 1975. She lived seven years more until 1982, when she was 82. She was born at the turn of the century, and that was a family milestone, not to mention that her birthday was April 1, 1900, and we often teased her about being an April Fool's baby. She introjected my father's managerial qualities at his death, but maintained her own empathy, interests, and, above all, her independence. Though she died on a visit to Cincinnati from New York when my oldest daughter was getting married, she had insisted on maintaining herself in her apartment to the end.

She often told me her dreams. And the dream she had the night before she died was of being in a narrow tunnel with a light at the end, and a shadowy form trying to take her hand, and she saying repeatedly and anxiously, "Not yet, not yet." She interpreted her own dream as her unwillingness to die. But that evening she stripped herself of her rings and valuable possessions, such as her diamond pins, and gave them to me as one would when going off on a journey from which one will not return. I missed her much more than I missed my father.

In each of these sections I will make some comments about love and intimacy in the last quarter of life. Just recently I saw two patients, and both of them expressed a wish to no longer live and based it totally on the fact that "nobody loved them." My mother, a singularly attractive woman even at the age of 79, was pursued quite actively by a retired physician. It was clearly going to lead to marriage since he had been a widower for some five or so years. But she was totally loyal to my father. She had married at the age of 17 and they had a marriage of fifty-eight years duration, and she could not see relating intimately to another man.

On the other side, she was a very self-contained woman, and when my father asked her to climb into his railed bed for a few moments of cuddling she refused him. She regretted this bitterly, and mentioned it several times before she died herself. She wished she had

done this, but she had some peculiar aversion to cancer "transmission" which she knew was irrational.

My grandfather died at 84, after he was a big winner in a poker game. When my father found him in his apartment, which was at the back of my father's dental office, he had a huge number of dollar and ten-dollar bills in his wallet. He was a former rabbi, who had turned to playing cards with either his grandchildren or his peers, and spent his time in intellectual conversations, reading newspapers, and pursuing his minor hobbies. My grandmother, on my mother's side, who was also the surviving grandparent, ended her life among many women friends. And although a good-looking woman, she was totally involved with her seven daughters and their children. As far as I knew, she never pursued any hobbies, but was a totally congenial, good-natured woman, who was very careful not to impose on our nuclear family.

PATIENTS

As I write this chapter, I realize that I know more about my patients than I know about my own life and background—this despite inquiring all about mine, through analysis, and having an insatiable curiosity about all family trees.

I shall talk about four patients: Mrs. C, Mrs. M, Mr. T, and Mrs. S.

Mrs. C was an 82-year-old woman who consulted me for depression following three major losses that had occurred simultaneously. She lost her best friend, who was her age; she lost her dog whom she had had for twelve years; and probably the greatest loss was the loss of her vision via bilateral retinal hemorrhages. She was a Swiss woman who had been trained as a nurse, and had come to the United States to live with an uncle. She had never married.

The therapy went the way the patient directed it, as usual. Her mind went immediately to an early experience, when she was 8 years old, which had occurred in a park in the little Swiss village in which she had grown up. Four or five boys, two or three years older than her, had induced her to go to the park where she had pulled down her pants and exposed herself, and they in turn had exposed themselves to her. She found this exciting and felt particularly the intense object of much older male attention. However, a friend of her mother's had seen the episode and reported it to her mother. Her

mother and father called her in (remember she was 8) and told her she would turn into a whore if she continued this way of life, that she was no good, and was a poorly controlled little girl. This occurred in a middle-class family of some status in the community.

She felt that this had affected her her whole life (cf. the concept of the negative ego ideal as written by Drs. Kaplan and Whitman [1965]). Subsequently she had lived a life above reproach. She was very careful in dating; she was even very careful never to be alone with a boy. Though she had fallen in love several times in her twenties, and indeed quite passionately, she had never allowed herself to get intimately involved with a man because of the dire warning that her mother and father had given her. Following repeated discussion of this in psychotherapy with me in which I wondered whether her parents had really been quite fair to her at that age in being so critical of her, she brightened up considerably and some of the depression began to lift. At the same time, she had an experience which she described as almost dazzling to her. She had awakened from a dream about a tall, thin mountain in the Swiss Alps (much of her early life had been lived in the shadows of the Alps) and she felt increasing sexual excitement as she approached the mountain. She woke up, was extremely erotically stimulated, and with several caresses to herself had the most complete orgasm she had had in her entire life. She and I both related this to the discussions we had had about the mother and father's severe prohibitions in her early latency. I continue to see her in psychotherapy, now once every two or three weeks, and she continues to feel that the relationship with me is what sustains her despite feeling "that she is not loved and therefore has little to live for." She is resisting giving up her own home and going to a nursing home where almost all her friends are, but that is the topic of our current discussions.

Mrs. M returned to me after a twenty-five-year lapse, because she felt that her difficulty in walking was not due to organic factors though she was 84 at this time, but rather related to a neurotic conflict. After her husband died when she was 72, she had become very close to a man who wanted to marry her. She did not do so because she felt that their ways of life were too different, he being Jewish and she being very ardently Presbyterian (her father had been a Presbyterian minister). The man had moved away from Cincinnati to California and they had kept up an exciting weekly correspondence, and the arrival of his letters was the highlight of her week. Then, one day,

and she is still puzzling as to why, she wrote to him and said, "Isn't this all a sham—we will never really get together!" His subsequent letter did not come. So she called him in California. There was no answer at his apartment. She became very guilty about her letter and in two weeks a phone call came from the man's son. He had found her letters among his father's possessions and thought she might be interested to know that his father had died several weeks before. She agitatedly traced it to one week after he would have received her letter. She then felt that she had been the one that had caused his heart attack, for that is what he died of. She said she knew that I would say that it was omnipotent thinking, or grandiose, but nevertheless she could not shake the feeling of guilt that she had contributed to his death. Since then she had intermittent difficulty in walking. Examination by a neurologist had produced no findings. She asked to return monthly to see if she could talk it through.

Mr. T was a retired executive of a large company in Cincinnati. When he did not become president of the company, he decided that he would rather retire and pursue other interests, particularly organizational consulting opportunities. His wife, on the other hand, had developed a second career in art history and was avidly and successfully pursuing it. He became increasingly impotent with her, although they were both in their sixties, and he felt that there was some psychological causation for his problem. I saw him for several visits in which he expressed some of his unhappiness about his early retirement, his disappointment in not having gotten the presidency of the organization, but professed a great deal of love for his wife and felt it could not be resentment toward her that was contributing to the sexual problem. He then brought in a dream in which he found himself waving good-bye to his wife as she went off to work, only to find himself not at home, but rather in a mental health institution. This began to make him increasingly uncomfortable and his discomfort was even multiplied when at the institution he perceived the fact that almost all the males there were homosexual and some of the men began to approach him. He awakened with great anxiety.

We were able to work out together that the reversal roles in his family had made him feel feminine, and therefore homosexual. Indeed, he did have resentment toward his wife, not because of her going to work but because she did not respond sufficiently empathically to the reversal of roles in their marriage, and often asked him to cook for her when she returned from work, thus increasing his

feelings of femininity. I then met with the two of them together and she was very receptive to some of his complaints, and in a period of four months of once-a-week therapy the symptoms disappeared. I see them occasionally socially and they are doing extremely well together.

Mrs. S is a 62-year-old woman who owns an interior decorating business. She is so successful at it that her husband has joined her in the business and they have made a financial go of it. The great pain in her life relates to their last child who was born with cerebral palsy. Mrs. S had had this pregnancy when she was in her forties, and though a strong Catholic had seriously considered abortion. The pain of this child is not its current functioning, but the fact that Mrs. S, though completely composed about her own potential death, is totally anxious about there being no one to care for this daughter who is unable to function alone. It reminded me very much of one of the themes in the *Race Against Time* (Nemiroff and Colarusso, 1985) in which the authors say that there can be no recompense for the death of an adult child no matter how empathic and deep-going the therapeutic relationship might be.

THE AUTHOR AS AN AGING PERSON

In June 1990, I was 65 years old. Though many authors in the literature talk about the great advantages of aging, it is difficult for me to see that (or many other seniors I speak to). But there is one specific positive, concrete advantage in tennis, which I have played all my life. Each new age accession pushes one into a new category of competition, and those tournaments begin on January 1st of the year when one turns that age. Thus, on January 1, 1990, I became eligible for competition at the 65-year-old level. I immediately was hustled into going to the Southern Indoor Championships in Tennessee by a 66-year-old friend who understood the edge that one gets when one enters these new age categories. We ended up winning the Southern Indoor Doubles Championship and received a U.S. Tennis Association Gold Medal for this achievement (my other tennis goal is a gold ball which one receives for winning a national tournament; this tournament only being a sectional one).

But talking more seriously about the two other aspects of life, love and work (tennis being a third, i.e., playing). I took a six-month sabbatical, and had a test run on what I want to do about the problem

of retirement. I have learned that I enjoy seeing patients and writing the most, but have become somewhat impatient with the administrative aspects of psychiatry. I have just finished almost ten years as Chairman of the Department of Psychiatry at the University of Cincinnati.

Being a chairman in a medical school is a complex position with a complex number of interrelationships. But when I asked to be relieved of the position, the most significant of all the things I could point to was the fact that I did not like what was going on within myself in terms of preoccupations. Whereas at one time I could call up the literature, quote articles and references on various psychiatric and psychoanalytic works, suddenly I knew the salaries of everybody in the department, what the budget items were for various allocations, or what the medical center needed to complete its medical arts building. Administrative preoccupations are boring, not only to other people, but worse to oneself.

In 1965 I was divorced from my first wife after sixteen years of marriage and three children; I remarried in 1968. My wife of twenty-five years, Esther, has raised two fine children with me (one at Princeton and one at Michigan) and our marriage has been an enriching experience for both of us. Raising a second family gave me a certain amount of difficulty with the grandfather role when that developed with the progeny of my two oldest children from my first marriage. While I was still struggling to see myself again as a father, I suddenly was being called grandfather, and I wondered within myself whether this was always such an acceptable role to aging men. My image of my grandfather was not of a vigorous, active man, but rather as I have written above, somebody who frittered away some of his talents and intellectual ability. I shared this perception with the head of the outpatient clinic in our department, and he was vastly relieved to hear my feelings since his were similar. He had felt a good deal of guilt about his unwillingness to step into the grandfather role as well. My middle child is a Fellow in Child Psychiatry at Cornell and in analytic training. She still sees me as father since she is not married and is without children.

MY SIBLING

There is no doubt in my mind that the importance of siblings greatly increases as one grows older. I think it is insufficiently mentioned in

the literature on aging and probably insufficiently mentioned in the psychoanalytic literature. But I have had numerous clinical examples now where siblings were all-important to patients in analysis with me, and that the transference to me was often of an older brother.

My only sibling, my older brother, retired from dentistry (similar to our father) at the age of 63 to Boca Raton, Florida, where he joined an active community of retirees and where he plays tennis and golf each day and bridge in the evening. For the first four years of his retirement he claimed total happiness. But just recently he admitted to me, somewhat shamefacedly, that he had a certain lack of purpose in his life and felt a little at loose ends. It was particularly difficult for him to admit this to me since we had argued about this issue a number of times, and I had told him that though I was going to retire from the University, I would not retire from my active practice, reading, teaching, and writing.

I have watched him in retirement, cutting a pathway for me, much as he had done in so many other of the adventures we had undertaken in our lives. Our parents were laissez-faire parents, and though we were both national champions in table tennis, neither of them had ever seen us play a match. Though I was a junior champion of New York in tennis, they had never seen me play a game of tennis. But they were of that generation, my parents, who let children grow on their own. Certainly, as one reads the case histories of patients with overinvolved parents that Freud described as leading to hysteria, and the overanxious parents of our own generation, there is much to recommend uninvolved parents.

As might be expected with two boys growing up in the family, we were very competitive in all areas. I exceeded him in most areas, partly because I had the advantage of his being the pathfinder and partly because he bore the brunt of my father's oedipal wrath, which I watched with fascination, but stayed away from as much as I could. He also had three children from his first marriage and now lives with his second wife in retirement. He continues to be a leader for me even in illness and his prostatectomy preceded mine by a year. Our phone bills are large but easily worth the level of communication we achieve and the "in" jokes we share from our lives. We see each other once or twice a year in addition to the telephone, and reminiscing is an important part of our visits.

STORIES, JOKES, AND READING

I would like to deal only with those stories that have stuck in my mind. Clearly they had some dynamic significance for me. My mother would often tell the story of the old grandfather who was impatiently given a wooden bowl and told to sit in the corner of the kitchen because he would constantly drop his pewter bowls which would break, causing terrible irritation to his son and daughter-in-law. One day their little boy, the grandson of the banished grandfather, took a wooden bowl and put it high on a shelf with a wooden spoon. The mother and father watched him curiously and asked him what he was doing. He said, "I am putting this wooden bowl and spoon away, so that when you two grow old you also will have a wooden bowl to eat from and can sit in the corner and not mess up."

Another story that always touched me: the story of the mother who waited at the nursing home on the porch. One day, in a fit of guilt, a late fiftyish adult male decided he was long overdue to take his mother out for a jaunt on a beautiful spring day from the nursing home. He thought he would surprise her, and drove up in his car only to be astounded to see her sitting on the porch with a valise packed, clearly waiting for him. He said in astonishment, "I am amazed that you are here sitting waiting for me. How could you possibly have known I was coming today?" She answered immediately, "I sit here with my bag everyday waiting for you."

Jokes that I have heard, some quite recently, have to do with aging, sexuality, and particularly memory and Alzheimer's disease, which seems the great fear of the older men and women I have talked to.

An older man and his wife, he now 78 and she 70, returned to the small inn in the Carribbean where they had first taken their honeymoon some fifty-five years before. When I asked him how it was, he smiled and said, "I remember we sat on the bed together when we were in our early twenties and as I was about to approach her, she cried and cried." He said, "Now, as I am about to approach her, I cry and cry."

The 98-year-old man and the 95-year-old woman came to see their lawyer. "We have finally decided we want a divorce." The lawyer was completely taken aback. "All these years you have lived together and now you are asking for a divorce?" "Yes," they answered. "We were waiting for the children to die."

And finally, the memory jokes. If you have Alzheimer's disease, (1) you can set up your own Easter egg hunt and still enjoy it, and (2) you find you make new friends and have a new family every day.

The jokes deal with diminished sexuality, fading memory, marital changes, and great old age, and finally the painful loss of memory of which Alzheimer's is the epitome.

And finally, some of the reading that I have done through the years in this area includes Nemiroff and Colarusso's book *The Race Against Time* of which Martin Grotjahn's chapter is the most moving. Grotjahn talks about being hospitalized and says, "When I came home from the hospital, I had become old." Another quote from Grotjahn impressed me: "I always thought old age is an achievement in itself. I now know better: to get sick and live on, *that* is an achievement!"

I would like to end my essay with a quote from Jonathan Swift in *Gulliver's Travels*:

> Every man desires to live long,
> but no man would be old.

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15

Some Autobiographical Notes By a Psychogeriatrician in "That Time of Year": The Role of Devalued Fathers and Adopted Great Parents

Stanley H. Cath, M.D.

That time of year thou mayest in me behold
When yellow leaves, or none, or few, do hang
Upon these boughs which shake against the cold,
Bare ruined choirs, where late the sweet birds sang.
In me thou see'st the twilight of such a day
As after sunset fadest in the west;
Which by and by black night doth take away,
Death's second self, that seals up all in rest.
In me thou see'st the glowing of such fire
That on the ashes of his youth doth lie,
As the death-bed whereon it must expire,
Consumed with that which it was nourish'd by.
This thou perceivest, which makes thy love more strong
To love that well which thou must leave ere long
[W. Shakespeare, 1609, Sonnet 73].

As interpreted by Professor of English poetry Helen Vendler (1989), at a recent meeting of the "Friends of the Boston Psychoanalytic Society," Shakespeare is telling a young man how it feels to be old. In successive quatrains the poet uses three analogies to aging. The first two are morbid metaphors of time; yellow leaves upon a bough shaking in the cold, late in the season of life, and "In me thou see'st the twilight of day . . . taken by black night to be sealed all in rest." By

contrast, in the third quatrain, he seems to rethink and recast the meaning of age in terms of intergenerational relationships. No longer cold, he still has within the glow of a fire "consumed with that which it was nourish'd by." Moreover, he assumed that when this fact of life is perceived and shared by different generations it will cement the bond between them and make love more strong.

Resonating not only with Shakespeare's insight but with Dr. Vendler's fine commentaries, this aging psychiatrist easily recalled a goodly number of glowing, nourishing, and consuming experiences from all phases of life. While listening, I thought of Dr. Pollock's invitation to do this chapter waiting for me at home. Strikingly, my associations led to a host of mostly departed elders, the interactions with whom had been determined by transference and countertransference to both adult and elderly people. But in my experience this fine distinction between middle and late adulthood probably was not too clear until latency. As I experienced an anxious awe at the sheer beauty and wisdom of a brilliant poet on a topic few can tolerate, I did what I so often do. Inwardly I began to intellectualize on how genetics and the vicissitudes of the birth experience, interact with parental characteristics to later determine not only immuno-competency but the ratios of "consumption and nourishment" in a host of subsequent relationships. Vendler pondered the reason for Shakespeare's not having chosen "lose" rather than "leave" in his last couplet. Is there not revealed, in this choice, Shakespeare's protest against the finality of human destiny? I went over his lines again and again, reflecting on his creative affirmation of the restitutive characteristics of late-life connectedness I had so controversially written about a quarter of a century before (self–other constancy challenged by loss and efforts at restitution). It might be said this sixteenth century poet had described in fourteen inimitable lines the painful essence of growing old, namely the changes in one's body and mind, the responses in one's self and in others to these changes, and, above all, even the strengths to be derived from the leavings of those one has lived with and ambivalently loved.

My deep resonance with Shakespeare had always puzzled me and now to discover how much his writings resonated with my own pathetic attempts appealed to my grandiosity and tempted me ever so slightly to reconsider a belief in reincarnation. Indeed he lives on in me precisely because he had been and still is one of my favorite

"great" adopted parents. I remembered he had written other lines elsewhere that could be considered harbingers of my own concepts of "depletion and depletion anxiety" (Berezin and Cath, 1965); for example,

And so from hour to hour we ripe and ripe,
And then from hour to hour we rot and rot;
And thereby hangs a tale [*As You Like It*, Act II, Scene vii, l. 26].

Over the years I have used this quote in teaching, always counterpointing its pessimism with Browning's more optimistic, youthful invitation:

Grow old with me!
The best is yet to be,
The last of life, for which the first was made [1864].

In Sonnet 23, however, Shakespeare prefigures the goal of modern gerotherapists of any school, namely how best to be a comfort to the aging in their attempts to restitute for depletion (therefore to everyone eventually) and to their families who are all too soon to be bereaved. Whatever a dead poet intends can only be guessed at, but certainly his quatrains portray universal phases of late life. Much of Shakespeare's thinking seems surprisingly therapeutic, especially the last four lines of Sonnet 23. An approach to "Shakespeare as a psychotherapist" has been unattended to by all of the scholars I have read. Yet, the last quatrain would restore dignity and purpose to aging. To be sure it provided me with a measure of solace in my personal struggle to accept the vicissitudes of the steady passage of time and my fears of a future marked by "shaking boughs." The indications of arthritic degeneration are sufficiently evident in me to presage the same limit in my future mobility I witness in others every day. But the total impact of this poem was to help focus this essay into a particular search for "analytic data" as I wondered about the sources for my personal glow within. This then is a partial record of the personal development of that glow in the settings of human connectedness with mature and elderly people I have loved and had to leave "ere long."

RELEVANT GLOWING EMBERS

I decided to look at the influence that both positive and negative imagoes of aging have had in creating the "glowing embers" along my life's path than toward a new appreciation of special knowledge gathered from experience or training. Thus, I began an intrapsychic inquiry of myself vis-à-vis patients, family, and friends. How and why had I come to enjoy elderly people enough to tolerate the pain of inevitable, repeated confrontations with human vulnerabilities and the inevitable separations endemic to the field of geriatric psychiatry? Was my affective endurance related to anything I had learned as a professional or were "living introjects" of equal if not much greater significance? I knew I had always felt older than most of my age-mates and had always looked primarily to older people for affirmation and respect, both as casual friends and as confidantes. Yet, could there not be still an undue, subtle obsession with morbidity and mortality within the fabric under examination? Had my mother's preoccupation with the early death of her father from cancer when she was 12, unwittingly identified her with the third dreadful sister (of fate) Atropos, who carries the shears with which to snip the thread of life? The answer had to be in the affirmative to some degree, but these associations remain a complex to be addressed at another time.

The first imago I encountered in this mental exercise was my maternal grandmother who had lived with us one summer when I was 4. The tonal quality of that memory is symbolized by the loving warmth of her taking a golden chollah out of the oven every Friday as we prepared for the coming of the sabbath bride. This image of loving nourishment-consumption contains both the detailed warmth of a Breughel and the nuturant mistiness of an early daguerreotype of grandmother and child. Her husband had died of stomach cancer in his forties when my grandmother was only 42. My mother's memories, as well as family legend, painted him as an idealized, warm, loving, hardworking and productive man. "If only he had lived longer," she would muse. I do not know when I apperceived that in the minds of my mother and grandmother I had inherited his mantle. A specific wish-imperative of long life associated with his resurrection had been transferred to me by both of them at my birth.

My paternal grandfather, a successful, uneducated immigrant turned entrepreneur, lost everything in the 1929 crash. Shortly thereafter, in his early sixties he died of a stroke when I was 8. This disaster

left me with a second mandate from the older generation, namely that of the single male grandchild "to carry on the name." One of my most vivid memories of this powerful man, portrayed always as destroyed by economic circumstances beyond his control, was his breaking out of bed restraints in a poststroke confusional state. He was the first person I can remember who became irrational and violent. His funeral was the first time I remember my father in tears.

My paternal grandmother, a true matriarch, survived him for over three decades as a poker-loving widow who ran everyone except me. For some mysterious reason, she had pinned her hopes for the future of the family on the skinniest, poorest, small framed but scrappiest of the many grandchildren around. She lived long enough to become one of my earliest geriatric patients.

From my perspective, then, the older generation of the first quarter of the twentieth century symbolized better times with greater mastery and less poverty and want than had my father's generation. In the depression years living was hard and humiliating. Hand-me-downs were a way of life; orphanages and poor houses very real, and in truth constantly in our minds. We did not own an automobile. On weekends we waited in hope for one of the richer relatives to take us to the beach or for a ride. Envy of those "better off" led me not so subtly to deprecate the life-style of certain rich, more leisured, and less educated relatives. In my mind, they worshipped youth, sex, alcohol, and material possessions and did not deserve what they had been given. By my college years, I detested myself as a "self-centered materialist" if I desired more than I needed or if I sensed I was like them. Any other tinge of prejudice against the inept, the sick, the aged, or the poor was a signal for debate.

As I mused further back in time, especially in regard to my determination to help the sick, the aged, and the poor, it seemed natural, if not quite conscious, that I would "design" a highly ethical, altruistic career somewhere in between the realms of medicine and psychology. The core of this determination now seems clear. Family myth had it that our general practitioner, Dr. Joseph Webber, saved my life when I had been severely burned at the age of 2. To all the neighborhood, he had been a kind, always available, Norman Rockwellian, family physician. When he appeared in the doorway, his warmth and reassuring smile could diminish fear even of the dreaded infectious diseases of the 1920s.

Until writing this, I didn't appreciate how significant he had been in setting up my adolescent, pre-Nazi "love affair" with Germany. His persona and German accent which fell lovingly on my ears had unwittingly prepared me to receive the creative work of one of its most brilliant sons and even his more controversial theories of psychoanalysis. It "took" especially because of Freud's emphasis on finding the truth about families. Also, the imperative need to look beneath the surface to expose the defensive hypocrisies of everyday life happened to coincide with a similar need-crisis in my own development. I also shared Freud's distrust of American greed and was predisposed by my family constellation to see the accumulation of power and economic success without moral restraints as dangerous. In light of recent developments, his concerns were more than justified. But it was Dr. Webber's unique German-Jewish cultural amalgam that pretuned my ears and heart for future contact with all the Viennese originators of this "science." As a handsome, graying Jew of Austrian heritage with a twinkle in his eye and a distinguished accent, he personified the best of what I later came to appreciate as a unique Jewish-German fusion of science and humanity. A far cut apart from those in my small, undistinguished world, his mature presence set an entirely different affective tone.

We happened to live on the fringe of a Jewish-American ghetto surrounded by ethnic Irish and Italian working-class people. For the first three years of school the path between home and school became my personal, daily, long march of terror; I experienced anti-Semitism intimately. Escape from hostile peers and rescue by older adults became major themes of my life-song. Thus the armature of my nascent ego around which I wrapped my injured self-esteem and my hopes for escape from social limitations and unjustified persecution as a Jew, was an identification with Dr. Webber and a series of respected "great elders." It would not be until a decade later, in a middle-aged high school German teacher, that I would rediscover this unique culture again. But that enriching experience coincided with a rapid sequencing in adolescence in which I encountered the enthralling music of the three B's, Bach, Beethoven, and Brahms; the still puzzling theories of Einstein; and the incomparable, illuminating writings on the mysteries of human nature by Sigmund Freud. My childlike, extremely anxious puzzlement about what it meant to be a Jew had been counteracted to some degree by Dr. Webber's calm, poised, enlightened presence and ambience. This early contact with a mature, idealized, powerful

but kindly figure remained a constant imago in my life and played a major part in determining what lay ahead.

With him as a model, from preschool on, my mother and I had silently compacted that this frightened, skinny, little Jewish boy was headed for medicine and the security-respect such a profession might bring. It is hardly surprising that I responded with almost as much shock and disbelief to the slowly dawning awareness of what was evolving in Hitler's Germany as those living there. In my mind I had been born in that great fatherland through which my mother had traveled on her way to America. I had learned at her knees that for a night, through the influence of a distant cousin, she and her family had slept in the Kaiser's palace. The fact that my father had run away from school to enlist in the army in World War I did not detract from my increasing admiration for German genius. Dr. Webber had become my first adopted, great father and Deutschland my fantasied home, an amalgam of culture, music, respect, and adopted great parents.

But this solution was too much a figment of my imagination. It lacked the immediacy or the power to quell the restless search for a more idealized father than the devalued imago nature had provided. Happenstance had decreed that my father was an arbitrary, unstable, black sheep in a family of five children. His only brother, another favorite of my grandmother, was by contrast quite successful. My father's contribution to my oedipal inheritance was to reestablish the triangle in which he played the role of the critical, angry, unfavored child. He became a restraining outsider. Very early on, like Abe Lincoln, I started my quest for distal fathers who might appreciate rather than feel threatened by me, and who would thereby heal my flawed family image (Strozier and Cath, 1989). Late in life I found Abe and I had much more in common. We both read everything we could lay our hands on in order to explore other worlds than our own, even though we were the objects of our fathers' scorn when our noses were buried in books burning the mid-night oil and we were not working to make our fathers' lives easier. I conjectured both fathers opposed their brighter sons' educations for the same sibling and oedipal reasons, bolstered by the rationalization of the economic hardships created by their own ineptness. Both boys felt like slaves (Abe was equally "hired out."). In books we found the heroic, rebellious figures we needed. It turned out Shakespeare was both Lincoln's and my own favorite author. I believe Shakespeare may have had a similar kind

of father, or at least the man credited with fathering Shakespeare is so drawn in all available historical sources namely as a failure after midlife. Then Lincoln and I shared the same deep interest in classical figures, Caesar, Cicero, the biblical kings, and so on. I melded my mental representations of these extraordinate imagoes with the ordinate hard working teachers whose knowledge of the world and how it worked fascinated me. Their real and imagined qualities matched those to which my healthy narcissism and emerging ego ideals aspired, for they were such a clear contrast to my father who was relatively inarticulate, insensitive to nuances, obese, unemployed for decades, and helpless. Indeed when I was 12 we had been evicted for the second time, and had to move into a flat in my grandmother's house with nominal rent.

Relevant to this essay and my interest in the vicissitudes of becoming a grandparent was an important shift in my midlife perspective of my father. This was the realization that the best stage of his life was when he was an old, by then mild-mannered rather than volatile, beloved grandfather. To be sure this late accreted respect was tarnished by the awareness of his family that he was essentially saved by the prosperity afforded by the Second World War when he was able to finally find a job in a shipyard. Then he moved out of his mother's house, but had to be sustained by the contributions of his children. In contrast, by the age of 10, I had become a major producer of family income and fixer of any broken object around the house.

Speaking of objects, I have never recalled a personal transitional blanket or toy. It seems I attached myself to important, older people rather than to things. For example, when my sister, who was two years older, went to kindergarten and I was left without her companionship, I set up a friendship with a local mentally retarded, prematurely old character called quite fittingly "Easy." When not busy with his chores, we hung on the fence talking "easily" of those inconsequential matters that fill the days of young and old outside the mainstream of life. I began a pattern of dropping in on the parents of my friends or any friendly neighbors, and soon learned where I would be most welcome.

The first three years of school were disastrous, not only because of anti-Semitic boys on the way but because of a principal similarly inclined. Fortunately, in my fourth year my mother found out through my sister that my stories of persecution as a Jew were quite real, and arranged a life-changing transfer to another school. Within

a week my world brightened as one teacher after another accepted me and my efforts to communicate the ideas that seemed to bubble forth. Soon I aspired to be a teacher as well as the doctor who had been destined to alleviate the family's despair. It can be said I had won the oedipal struggle by an identification with a distinguished physician, a man even my father respected, but my mental integrity had been affirmed by the teachers that followed. It was no wonder my life seemed to exist within a Jewish mother complex with its promised salvation through a medical career. But freedom to think and to move came from older educators and those philosophers who transmitted knowledge to me, all wise, older people.

But the road was not so straight. A preadolescent detour was occasioned by an idealized Rabbi and almost led to the Yeshiva or rabbinical school. For a few years prior to my Bar Mitzvah my identification with the Rabbi and selected other elders in an orthodox synagogue seemed paramount. The paradox was that I had found a more immediate source of respect, dignity, and knowledge in the very same people whose exile, stamina, and reason for existence as a distinct entity had caused me such puzzling pain just a few years before. It was hard work to learn to read and translate ancient Aramaic into contemporary Yiddish, but the rewards of glimpsing my own people's exciting past through an immersion in the minds and languages of wise old men seemed worth the effort. It solved my latency need for separation from the ever present, powerful womenfolk who had dominated my preoedipal and oedipal years and served deep isogender needs unfulfilled by my father.

One other autobiographical facet of our family life needs be included here. It is relevant to the possibility of a morbid fascination with life and death. My younger sister, who was eight years my junior, was born with a patent ductus arteriosus. For many years she was erroneously diagnosed as having either rheumatic heart disease or pneumonia. We spent almost ten years in and around hospitals as she frequently lingered between life and death in an oxygen tent. I pondered how a just, compassionate God could allow this lovely blond child to die for she was beloved by all including her erratic father and me her older brother, who, though he was expected to be jealous, truly loved her. We were told she would be dead by 21. Religion was of some comfort to my mother but its explanations seemed increasingly vacuous to me. In my first year in medical school I learned of the pioneering work of Dr. Robert Gross and my sister's patent duct was

ligated. Today she is a lively mother of four and a grandmother of two.

By late adolescence, my doubting was slowly being converted to disillusionment by the archaic thinking, the inappropriate solutions proferred, and the rigid hostilities between various sects and temples. Despite each claiming to worship truth and justice on the sabbath, very few seemed to me to practice what they preached the rest of the week in everyday life. An imperceptible taint of intolerance and hypocrisy crept into and contaminated my perception of this ancient world of Torah maintained by ancient men. What a contrast to psychoanalysis, or so I thought then.

Fortunately, just after my Bar Mitzvah, a new series of relationships intervened to partially sate my hunger for a new measure of self-respect to counteract adolescent helplessness and insignificance. These interactions reiterated and reinforced the theme that my self-identity was to be derived not so much from peers as from more mature if not gray-haired elders. Two women teachers, one a guidance teacher and the other a middle-aged, lovely history teacher, came to the surprising judgment that I belonged in a classical high school. Until that point I had never heard of such a special setting for brighter children nor considered the option. With a new identity as a promising student, I began an imperceptible move away from religion, with its long Saturday afternoons devoted to philosophical discussions of the Talmud, into the more fascinating and much broader range of classical studies. I developed a deep love of history, literature, poetry, and philosophy. The peak experience of my fourteenth year was an invitation by an elderly, distinguished gentleman to read some of my poems to a local poetry club. I still remember walking on air in a state of pure joy at being accepted and admired by him and these knowledgeable elders.

Soon I found myself in between two worlds, one of senior scholars and the other of young athletes. The coach of the high school track team had developed the gimmick of approaching freshmen, even skinny, small-boned ones like me, with "you look like you could make an excellent runner." This seemed ludicrous until the day when reluctant to go home to ongoing acrimony, I found myself accepting his invitation to "come on down and try it out." Once again I had been rescued and recognized by an older person outside my immediate family. And he turned out to be right, as I soon won state meets in record times. Years of roller-skating to both regular and Hebrew

school (because my impoverished father felt we could not afford the trolley) had built muscles I didn't know existed. That realization along with a deeper appreciation of my indebtedness to elders came decades later in my transference to a very senior woman analyst. It illuminated the source of the surprise I still feel in the discovery of hidden strengths that may carry me along beyond ordinary aspirations or extremes of fatigue to counteract despair. These reserves helped me rebel against the categorical knowledge and the implacable certainty of talmudic scholars who accept reality as "that's how it is written." It became clear to me that no matter how well written, packaged, or cleverly intermixed with various illusions about or references to authority or the deity, greater truths about human beginnings and relationships would have to be found elsewhere. While grateful for the interlude of being thoroughly acceptable as long as I had faith and conformed to the religious beliefs of my elders, I soon left the religion having learned many valuable lessons. While a rather rigid, unchangig system in the external world had sustained me during an ambiguous but seriously distraught, early adolescence, it had become inappropriate to a burgeoning athlete with an increasingly doubting curiosity. But it had been a system that prepared me well to learn from the past, adapt patiently, and bide my time in becoming.

Meanwhile my explorations into the lives of great men who had made history or were inordinately creative led to a fascination with the human relationships that had originally forged and later sustained them, as well as the foibles that destroyed them. As I came to suspect all theories or belief systems designed to portray life as the heroic overcoming of external evil were too simple, D'Artagnan, Shakespeare, Caesar, and myself all became more human. Without awareness, I was invisibly evolving into "a Godless Jew." Still, I retained a deep appreciation both for the sustenance religion could provide and the rich heritage my ancestors had bequeathed in their efforts to forge a meaning to existence through turbulent centuries in exile.

I think my identification with these exiles is in part at least reflected in my work with the aged, for there too I find mirrored characteristics of tenacity, endurance, and adaptability in the face of alienation and discrimination. Having been there myself, I knew how hard it was and is to sustain an inner sense of stability when under attack. It is hard to feel rootless and yet be bombarded with reprocessed theories about where we came from and who should be worshipped as being in control of our painful path and our destiny. This was

especially so when I understood that the only hope for relief is to be found in united effort. Finally, our purpose in being in this world was and is a still unanswerable question. The same may be said for whither are we are going. Indeed, I've recently reencountered the limits of my own capacity to comprehend even a marvelously simplified version of the origins, structure, and probable destiny of both the microscopic and the macroscopic universes. Stephen Hawkings, in his book *A Brief History of Time* (1988), supposedly simplified for lay readers, touched a most responsive chord as he opined that if modern, scientific theories about the origins and nature of the universe are even half right there was nothing for a God to do about creation ever! And so far at least an all-encompassing theory of the microcosm and the macrocosm has yet to be evolved.

What does all this mean in terms of countertransference in geriatric work? In my efforts to understand and work therapeutically with middle-aged and older people, I am deeply committed to accepting their version of their own inner reality and of their bodily states, much as self psychologists advocate with patients of all ages. No theory of the universe or version of reality can encompass or replace the psychobiological real experience of another!

Thus, part of my reverence for elders is rooted in the intrapsychic respect I have accumulated for the quite limited but still brilliant contributions of predecessors I have encountered in my studies and in life. I feel a kin among others to Isaac Newton, Shakespeare, Lincoln, Einstein, Freud, and Hawkings. And this reverence is centered on a basic love of the quest for knowledge formulated by people of all ages but transmitted faithfully across generations from teachers to students, while making allowances for the unique versions of the world each has experienced.

But geriatric psychiatrists are oftimes intimate, pained witnesses of the decline and disintegration of great minds as well as of ordinary ones. Sons of black sheep or devalued fathers do more than hunger for intellectual input from great and idealized men. While they try to become more ideal, they struggle mightily not to reenact the original father–son relationship. Ideally they gratify their need to keep their own and all adopted houses (families or countries) from "splitting asunder," earning the love, respect, and gratitude of the rest of the family or country. But then there is the secret guilt and inner sadness of it all which enacts a price. I consider Lincoln, who married an improvident woman with whom he could reenact his familial rescue

fantasy, while trying to avoid the shame "mother's" (as he always called her) impecuniousness could and did bring. The longing for more idealized others is almost always destined for disappointment. Witness Freud's friendships and destiny. Intense identification always makes losing idealized patients even more difficult for it is like losing a part of oneself. Like Abe Lincoln I have adopted the notion that certain great men and women had informed, enriched, and in effect created me with their seemingly more perfect world of ideas and ideals. Only as I wrote this chapter did I come to consider them and not my training as the major imperatives in producing a geriatric psychiatrist.

Paradoxically then my aging seems to connect me more firmly with an ongoing chain of humans who have attempted to understand the architecture and dynamics of visible and invisible life on this planet in order to take increasing control over an uncertain and anxious destiny. Hidden deep within, however, is a repudiation of a part of my devalued past, especially in terms of my relationship with my father and an ongoing need to be a more ideal family physician.

CONCLUSION

I truly believe an age-dependent intellectual reappreciation of the meaning of the passage of time with all its vicissitudes is ongoing in myself and in everyone. I have certainly witnessed it in the elders around whom my identity is wrapped. I know it sounds Jungian or unreal to propose that this intrapsychic process feels like a structure or an extension of myself. While primarily formed by aging mentors, living and dead, it feels ageless. How naive it sounds, but be assured I accept this psychic state can only last as long as the balance I described in my early writings (see references below) between normative depletion and diminished restitutive capacities in the long-lived is predominantly positive.

In summary, whatever drives me to be an enduring geriatric psychiatrist is above and beyond the bare characteristics of physiology, psychology, and training. At its core, it consists of loving and hateful gifts from peers and elder forbears which have provided me with the capacity to work with, medicate, and do psychotherapy even with the most regressed if not demented elders. In my late sixties, in the model

of a family physician, I still do home visits and nursing home consultations. I confess considerable, recent burnout in the disheartening atmosphere of some of these economically motivated, all too often family and state abdicated, warehouses of expectant death called nursing homes. But in the model of Dr. Webber, even as I appear ever more like my charges, I gratefully care for the residues of the beloved ordinary and great persons I have known wherever they may be.

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16

September Song

Mortimer Ostow, M.D.

In writing about aging, the aging psychoanalyst enjoys the advantage of having personally experienced states of mind that he or she is describing. The disadvantage is that the writer is limited by the defenses that naturally accrue to this situation and that necessarily impinge upon objectivity. In any event, it is difficult to distinguish between those insights that have been achieved by clinical observation and those inferred from introspection. In what follows I shall not attempt to make that distinction.

That aging is an ordeal for all who survive long enough to reach those ages at which important functions fail, needs no demonstration or confirmation. The religions, cosmologies, and philosophies with which our species has attempted over its history to render the cosmos hospitable can offer few words of genuine comfort. There are those systems that deny death, most commonly by positing an afterlife, or a general or partial resurrection of the dead, or sometimes by preserving corpses in a cult of the dead as the ancient Egyptians did. The exaggerated longevity attributed to characters in the Pentateuch, especially in its earliest chapters, suggests an attempt to imply that life need not be considered necessarily so limited in duration as it now seems. To this day, traditional Jews may wish each other a life of 120 years, the age attributed to Moses when he died, with eyes undiminished and his "moisture" unabated. In fact, even in the Pentateuch, the attributed life span decreases as the heroes change from mythical to merely legendary.

Other approaches encourage facing death frankly. The Bible does not lament natural death, only premature death, for example, as a result of foul play or in childbirth.

I find it interesting that there is little concern in the Bible with illness and senility as factors influencing human affairs. That deemphasis is consistent with the principal thesis in its historical books, namely, that God plays a determining role in human history, and collective virtue is appropriately rewarded, while collective vice is appropriately punished. The accidents of individual human life are of little consequence. Yet even there, some stories come to mind in which the limitations imposed by age seem to play a role. Jacob was able to deceive his father, Isaac, and obtain from him the blessing intended for Esau, his older brother, because with age Isaac had become blind. The beginning of Kings I records David's senescent melancholy which required the intervention of Nathan the Prophet and Bathsheba, Solomon's mother, to ensure Solomon's succession to the throne against the threat by Adonijah, his older brother. (In both instances, the senile disability of the father plays a role in determining that the succession goes to the younger of two sons.)

The Psalms take cognizance of the fear of approaching death and offer trust in God as a foundation for salvation. Ecclesiastes (in chapters 3 and 12) encourages equanimity throughout life so that the prospect of aging and death will seem less threatening.

The problems encountered as one advances to the last decades of life need no specification or elaboration here. They include: the disabilities caused by the diseases of age affecting the function of internal organs, organs of perception, and limbs; the changes of skin and of body structure that take away from the aesthetic attractiveness of the individual; loss or diminution of sexual capacity; the loss of the companionship of spouse and contemporary friends; retirement from work which means loss of one's special role or niche in society; loss of earning power; loss of social status that occurs by virtue of retirement from work and loss of earning power; and most distressing and feared of all, loss of mental capacity. These are the actual visible and perceptible changes, but much of the unhappiness is based upon the mental attitudes that anticipate or accompany or follow the changes, and that react to the expectation that one's identity and self feeling will be seriously altered by these changes.

Perhaps the most salient source of psychic distress is the fact that the future becomes progressively more curtailed. Throughout life we

are encouraged to give up current gratification by the promise of new ones: the future will provide a wider variety of pleasures than the past. As we approach the end of life, gratifying activities that have rewarded us for decades become obsolete, but there is nothing to replace them. The future progressively disappears. We mourn the losses that we incur, whether of loved individuals or enjoyable activities or cherished positions, but the mourning cannot be completed because the world cannot be reconstructed.

As the passage from present to future proceeds, and as the future becomes progressively impoverished, the aging individual becomes more and more acutely aware of the passage of time. It is a common observation that the older we become, the more rapidly time seems to pass. The year is endless to the small child, but a brief interval to the older person. The aged individual wonders whether he will survive to participate in family milestone celebrations, or to attain subsequent birthdays or significant calendar dates. The calendric structures of time, the weeks, the months, the years, the decades, family anniversaries, national and religious holidays, gradually change in aspect from events to be anticipated, to events whose passage is to be regretted. Business transactions now require an additional kind of input: Am I buying or leasing or investing for a term longer than my own life expectancy? And is that a prudent thing to do?

Most old people are dismayed to find themselves envying the young ones, even their own children, grandchildren, or students, and taking bitter comfort in the thought that their day will come too. One mean, depressed old woman told me that when she saw babies, she immediately imagined them in their coffins. While this is a pathologically extreme fantasy, the tendency is probably universal among old people, though they seldom permit themselves to acknowledge it consciously, or for no more than a moment. But when it does come to mind, it distresses most old people to recognize the depth of their ill will. Obviously this is the negative side of an ambivalence, greatly overshadowed by the positive side which we shall mention below.

We seem to have a tendency throughout life to cast our gratifications in the mold of our earliest infantile pleasures, essentially rejoining mother in the sense of reaching her or uniting with her, imagined in some literal way, or being fed and welcomed or invigorated by her. The evidence upon which I base this proposition is the frequent rebirth dream, in which one recognizes both the wish for a currently appropriate gratification and a symbolic representation of

rebirth by reunion with mother. For example, a woman dreamed of a flood in which people were drowning. In the dream, she and her family, however, were safe aboard a comfortable boat which was attractively furnished and provided with food and utensils. The day residue included references to the redecorating of her home, and her active concern with a philanthropy that rescued unfortunates. Symbolically the boat alludes to the feeding and protecting mother.

My experience with aging individuals discloses a strong propensity to dream of journeys, by auto, by railroad, by boat or by plane. The symbolism suggests the goal of rebirth by reunion with mother. Often the symbolism is reinforced by some detail from the day residue that confirms the interpretation. However, the hoped-for rebirth journey almost always becomes a funeral journey. The destination is a cemetery or a mausoleum, or the companions on the journey are family members already dead. The rebirth fails. Such dreams occur commonly among the aging, but occur also among other depressed individuals. What they tell us is that the aging person's aspirations and endeavors are expected inevitably to fail, and even when they do succeed in achieving their professed goals, they leave the individual with a feeling of futility. Conscious rumination, too, leads to depressing rehearsals of one's final days, moments, and ultimately one's own funeral.

Guilt and shame plague the aged perhaps more than they did when the same individual was younger. The disabilities and frustrations that naturally attend aging are interpreted by the aged as punishment, usually for oedipal fantasies or more realistically, for current wishes to cling to established positions that should more appropriately now be relinquished to the young. These same disabilities associated with aging or with the disease states that accompany aging, the loss of erectness and turgescence, the wrinkling and pigmentation of the skin, create a troubling sense of shame. An older person may be ashamed of his worsening memory, or his impotence, or his incontinence, or simply his appearance.

The experience of abrupt change as opposed to continuity, is problematic both in youth and age. While vulnerable youth responds badly to experienced physical and mental change, essentially the loss of early gratifications, most young people rejoice in the broader life that is becoming theirs. Obviously the break in continuity, essentially in identity, that besets the aging, is profoundly disturbing. They fear discontinuity in the sense of self, that follows automatically as one

function after another slows down, becomes impaired, or fails. The ultimate change, the change in mental capacity and the associated loss of contact with the past, remote and recent, brought about by memory impairment, is especially threatening to all of the aging who retain some interest in self-observation.

There is obviously no way to make senescence attractive or enjoyable. Equally obviously some of us grow older more gracefully than others. It is relatively easy to grow old gracefully when one enjoys good health, good spirits, retains spouse and comrades, lives among close and loyal and loving family, has accumulated sufficient assets to be free of economic privation despite inflation, can indulge life-long interests, cultural and athletic, and functions socially within a cohesive community. I remember well an occasion when, as a young physician working in a research laboratory in 1948, a distinguished old colleague who had barely escaped the Holocaust in Europe, displaced now and almost unrecognized, would ask me to walk with him up and down the halls of the laboratory, as he tried to convey to me that pain associated with being "an old, poor, sick, refugee Jew." To the extent that the ideal state is wanting, and to the extent that he was chronically depressed in the past, the aged person suffers.

It is often said that the best guarantee of good health is good genetic endowment. Life-long diet, exercise, and other prophylactic measures, however, seem to be effective in prologing both vigor and life. It is easy to recommend good health care and prompt investigation of alterations in function. However, it becomes difficult to draw a line between appropriate attention to such alterations and hypochondria, that either sets in with age or is exaggerated by it.

Most older people know that as their business or professional life comes to an end—at least in its usual context—they can continue to function with some dignity at a consulting level. Where this is possible, it provides a comfortable fall-back position, and a transition, of shorter or longer duration, to complete retirement. It provides income, status, continuity and a feeling that one's professional expertise retains its value.

The availability of a close and loyal family, especially children and grandchildren, plays an important role in the comfort of the aging. "Grandchildren are the crown of their elders, and the glory of children is their parents" (Proverbs, 17:6). Family harmony cannot be manufactured on demand. It requires sound foundations and depends upon variables and relationships that are well known. However,

its importance should be kept in mind at the times when it is threatened by the critical situations that occur in the life of every family. How one behaves when seriously divisive issues arise should be influenced by a major concern for family integrity.

Remarriage after the death of a spouse is frequently seen as a solution for the disconsolate widow and widower. Where two suitable survivors find each other, the outcome, while they both live in good health, can be splendid. However, late, second marriages are not easily established. Older men generally look for women who are one or two decades younger. The aging individual, especially the man, may feel incompetent sexually, especially when challenged by a new and younger partner, and may resist marriage out of fear or shame.

Social issues that arise during midlife should be resolved without ignoring the fact that a firmly established place in a communal group can provide a significant degree of comfort and support in old age. The group may be a religious congregation, a social club, a string quartet, a bridge club, a tight association of friends, a political organization, or a fraternal society. Those who have not affiliated themselves when younger, will, in general, not be able to do so in old age. However, an affiliation established earlier can usually be extended as the members age together, or even in groups heterogeneous with respect to age.

The cultural attitudes toward the aged that prevail in the community profoundly affect their self-regard. Although much of present-day America is youth and future oriented, and therefore seems inhospitable to the aged, many communities within the country view age and experience with respect.

Again, some occupations are acutely time limited so that careers come to an end relatively early in life; for example, the career of the professional athlete or the professional model. Other occupations reward age and experience, such as the practice of medicine or law. Supreme Court judges are not obligated to retire at a fixed age, while surgeons in many hospitals are not permitted to operate beyond a specified age limit. Such considerations should ideally enter into the process of selecting vocation and career, but seldom do.

The psychiatrist belongs to one of the professions in which experience is valued more than dexterity, so that the aging psychiatrist is not looked upon with the same apprehensive suspicion that greets the aging surgeon with tremulous hands. With all of its pharmacologic

advances (in psychiatry), the technology has not outstripped the learning power of even the aging practitioners as it has in many fields in which technologic advance and complexity have proceeded more rapidly, such as ophthalmology or radiology.

I have obtained a great deal of gratification from my growing ability to perceive the relations among, and to organize into a coherent whole, hitherto isolated portions of my professional and intellectual working hypotheses and theories. I attribute this capacity primarily to the accumulation of experience and to the faculty that experience creates, to see relations among concepts and observations that one could not previously perceive. From my contacts with contemporary colleagues, I infer that this experience obtains fairly generally.

Religion is frequently thought of in connection with aging. Religion is not merely a matter of belief, nor a matter of observance of ritual or attendance at services. One of the most important ways of being religious is participating in a religious community. For that reason, many religious rituals and religious sacraments require either the services of an intermediary or the presence of a minimum number of participants. For the aging person, membership in the congregation and the fact that status is undiminished by aging provides both comfort and support. Such a person understands, though this may be unacknowledged, that there is comfort from the fact that his or her death will be properly recorded by the congregation, and that he or she will be remembered in various ways in its services.

Most religions foster the belief in a life after death, either the continuity of the soul, or a general resurrection, or reincarnation. The older individual who has been religious from youth will accept such beliefs eagerly, and even those who come to religion late in life, burdened by the worries of age, may become more receptive than they previously had been. And even when they deny such belief consciously, they may accept it unconsciously. The clergy are sensitized nowadays to the special needs of their older congregants.

Having observed many aging individuals, whether in my practice or among my friends, I have found that certain attitudes convey the impression of comfort and grace. Equanimity with full consciousness of the approach of senescence and its implications creates the impression that the individual retains command of his life, body and soul. It is not clear whether it is the equanimity that provides the self-control, or whether the individual who possesses self-control also conveys the impression of equanimity. However, to whatever extent equanimity can be invoked, it contributes to the needed peace of mind.

Equanimity also contributes to the appearance of dignity. Dignity elicits the respect of others, which in turn, supports the older person's self-esteem.

An alert sense of humor often accompanies equanimity and reinforces it. A humorous tolerance for one's failings creates a distance between reality as perceived and reality as felt, and it is that distance that favors equanimity. However, that distance may at times expand to the point where reality is replaced by illusion. People vary in the extent to which they can indulge in illusory thinking without breaking radically with reality. To a certain extent we all need illusion, but we must titrate it carefully. The major religions try to steer a course that permits enough illusion to sustain hope and prevent suicidal despair on the one hand, and yet avoid the danger of acting inappropriately.

In general, the parameter of psychic function that is most directly attacked by aging is self-esteem. Therefore aging is more difficult for narcissistic individuals than for those with sounder object relations. Whatever supports self-esteem may counteract to a certain extent those experiences and challenges that impair it. Appreciation by the community supports self-esteem and can be obtained by active community service, and by a dignified approach to aging and death. In fact, equanimity, humor, and dignity elicit the respect of the community and the latter supports self-esteem, which in turn encourages those very qualities in a mutually reinforcing circle. Self-esteem is also supported by the feeling that one is needed. The depressed older person will explain that he has no reason to live because he is not needed. I have seen any number of colleagues who have become depressed in their later years, to some extent at least, because their professional practice has deteriorated.

Many of us, as we age, look forward to the opportunity to cultivate interests that our careers and obligations have forced us to neglect. Some of us learn new skills or perfect old ones. Some apply themselves to cultural activities more vigorously. Yet I have the impression that as time for retirement approaches, many prospective retirees doubt that their secondary interests can adequately replace those that are being given up, or can provide a reasonable degree of self-esteem. While some find that the replacement activities are surprisingly gratifying, more, I believe, are disappointed.

Freud (1930, p. 79) observed that one of the major sources of gratification in human life is intellectuality. When aging impairs physical function, but leaves intellectual function relatively intact, the latter

may serve well to prevent boredom and frustration. Many older people find that the opportunity to pursue intellectual and cultural interests that they have not had time to indulge in the past, provides a good source of gratification.

Many older people discover too that generosity helps them to retain the respect of others as well as self-respect. Generosity, in whatever dimension, replaces the wish to be needed with the gratification of being appreciated. One's children and grandchildren and other natural objects of affection and generosity tolerate the foibles and needs of elderly relatives more kindly when the relative shows his love with frequent and generous gifts. On the other hand, divesting oneself of all financial assets can invite a King Lear scenario. Becoming or remaining active in philanthropy guarantees the companionship of fellow philanthropists and attracts admiration. Philanthropic generosity not only earns the respect of others, but does a good deal for one's own self-respect. Generosity with one's time and effort perhaps outweighs in gratification achieved, generosity with money alone, but each person can be generous with whatever form of wealth he or she possesses.

One can be generous also in giving up prerogatives, power, and status to appropriate successors. Such generosity can provide an effective antidote to the envy of younger people that naturally accrues. While professional and business success serves self-esteem, hanging on when retirement is appropriate earns dislike, disrespect, or contempt. Giving up clearly won professional or business or social achievements makes it possible to exhibit generosity to former rivals and to earn their friendship and goodwill. Generosity is not a quality that can easily be adopted in the later decades of life when it has been absent hitherto. But many older people learn its value.

To this point I have discussed changes that come about spontaneously with aging, and attitudes that can alleviate to whatever extent the distress that these changes bring on. I should like to add that all of these considerations can be introduced in psychotherapeutic work with the aging, clarifying their concerns and anxieties, making them aware of the defensive maneuvers which they have adopted, wittingly or unwittingly, and suggesting additional measures such as those that I have mentioned. Of these, I believe that generosity, equanimity, humor, and dignity may be most helpful.

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17

My Mother's Last Smile

Peter Hartocollis, M.D., Ph.D.

Reminiscing about herself and her father, the great French writer Marguerite Yourcenar (1980) said:

> Very early, from the time I was thirteen, perhaps, we thought of each other as equal, because age didn't matter to me. I am not aware that I speak any differently to a child of six than to a man of sixty. And I don't feel any age. From time to time I notice that I'm no longer as strong as when I was twenty, but such weaknesses might have afflicted me when I was forty. I might have suffered from sciatica or circulatory problems at that age just as easily as now. Apart from that, age means nothing. If anything, I feel that I'm still a child: eternity and childhood are my ages [p. 10].

I wish I could speak—and write—like Yourcenar. But I do feel like her about age, my age, though not necessarily about the age of others. As she said, "If anything, I feel that I'm a child: eternity and childhood are my ages." And nature has favored me in this respect. For, by everybody's account, I look much younger than my actual age, besides being blessed with consistently good health. Even though not athletic or very careful about diet and habits that promote physical fitness—joking about it with my younger sister's son who was wondering what kind of exercise I did to keep fit when he had already started developing a pouch, I told him that my only exercise was brushing my teeth every night—I do not suffer from sciatica, circulatory problems or even rheumatism as most people of my age do, including Yourcenar and her favorite emperor Adrian at my age or even

younger. But I cannot say that age means nothing to me, even though, like Yourcenar, I feel that I'm still a child.

Objectively speaking, age is something physical, biological in essence and physical in appearance: my size, the condition of my skin, the depth of my voice. But for the person concerned, age is mainly psychological: I am as old as I feel (Hartocollis, 1983).

For others, I am either old or young. I am a child, an adolescent, an adult, a middle aged or elderly person—and that I cannot deny; or, rather, I cannot afford to deny, whether I feel young or old, if I am to behave in a realistic, adaptive way.

When I was a child my mother and father were mature adults, my grandparents old people—and I never thought of them as ever having been any different. I still remember them as they were then, my parents mature adults, my grandparents old people, even though they aged more as I grew older. But I never thought of them as any older. And I never thought of them as children, even though I had seen pictures of them as children and heard stories about their childhood. And when I remember my mother in her old age, I shrink at the idea and I want immediately to forget, for I don't want to think of myself in her condition of old age.

It is not exactly the same with my father. For he died much earlier and much younger, in fact he died at about the age I am now. And that also I want to forget. I remember thinking when he died that he had enough years behind him, that he had lived his life. But I can't say the same about myself. And I am as old as he was, almost as old. In a few months I may be older.

Some great people died young, Alexander the Great, Mozart, Shelley, and Byron; and most great people were great long before they died, Goethe, Freud, and Einstein. What difference does it make then how young or old I am when I die? I already know that I will never grow old enough to be great, no matter how old I might be when I die. So I have to settle for something less, rather than giving up the effort to be someone, to satisfy my narcissistic aspirations, to prove to myself that I am creative. The fact that some people recognize my name used to give me satisfaction, but that is no longer so.

When I was a child, an adult was a tall and strong person, one who knew much more than I did, one who had much more power and authority than I did. And I wished to be like him—when I would grow up, of course. Likewise, an old man or an old woman was just that, big but stooped and frail, gray haired and wrinkled, his or her

voice trembling, the man holding a crooked cane, the woman wrapped in a black shawl and robe. People of different ages were different categories of people. They were not people like me who had grown big and old. I took their age to be an immutable condition. And I still do. Children are children, young women are pretty girls, older ones are women looking their age, sometimes looking younger, sometimes older than they actually are, old people are old people; and I am what I remember always to be.

What I feel about my age, or the issue of age in general, may be very personal. But I believe everybody feels very personal about his age, whatever it may be. Some people never felt like children, some people never stop feeling like children; even though they may behave like adults, they do not feel like adults. To me, many people who feel like adults do not behave like adults, like mature people, and I am sure they don't know how it is to feel like an adult. For most people feeling like an adult is just taking themselves seriously; or working hard and being worried about things. They just forget that as children they worked hard or they worried about things, that playing and worrying about perhaps trivial things were also serious matters for them as children. I do not forget. And as people are growing older, they may complain about their age, but only for others to hear it. They do not really believe they are old. They see old age, like death, as something out there, coming nearer perhaps, but not any nearer than children or young people do when afraid of ghosts or murderous robbers, of fatal accidents or death when they see it coming for someone else—and that someone else may be a child, an adult, an old person. Age is a very relative, elusive, personal matter. It can be described objectively, measured by birthdates and anniversaries, by size and appearance, by our years in school or in a certain job, by the number of dead people we leave behind, by actual events that become history. Age is a reality imposed upon us by those around us, by the way other people look at us or feel about us, our children and grandchildren, our employers or employees, our teachers or students; age is a reality determined by the way other people look at us, our contemporaries, whether they are children, adolescents, or adults, young or old. The way we feel about our age, however, is the way our unconscious makes us feel. And our unconscious, our id, is timeless (Freud, 1923).

Virginia Woolf (1976) was painfully aware of the process of growing old. She wrote:

> Every ten years brings, I suppose, one of those private orientations which match the vast one which is, to my mind, general now in the race. I mean, life has to be sloughed: has to be faced: to be rejected: then accepted on new terms with rupture. And so on, and so on; till you are 40, when the only problem is how to grasp it tighter to you, so quick it seems to slip, and so infinitely desirable is it [p. 588].

Unlike her fellow writer Yourcenar, Virginia Woolf did mind growing old. And so do I. Approaching middle age:

> December 29, 1959. "This morning I thought I was someone important," my patient said. "Who did you think you were?" I asked him. "I thought I was God," he said. "But now I know I am not."
>
> That is the way I feel too on certain mornings, free and creative, soberly expansive. I am thinking of the great things I may accomplish, the book I have wanted to write for so many years now, all the striking ideas I have about things and people. And I think about Beata, about a great adventure, romantic and cynical, unscrupulous and without consequences, to sin without sinning—which might be if I could convince her to feel free about it, without fear or guilt; and, of course, if no one ever found out about it. But, unfortunately, she is in analysis, her analyst will know it and he knows me. And I am in analysis, too, in training analysis—as if I didn't have enough training in my life. When I think about it, I know I am not God.

Twenty years ago:

> June 2, 1968. Starting again—I've lost the habit perhaps, but tonight I felt like putting my thoughts down on paper, keeping a diary again, the idea of confessing for the sake of confessing, speaking without an audience, just for myself, avoiding the pretense, the self-consciousness of an audience, something like being in analysis again, without even an analyst behind me, just with myself and posterity—what posterity? I say it with embarrassment. For I have the feeling I did not succeed in my analysis. And as I say it, I am ready to argue; like I did with my analyst—my narcissism hurting, like an inner audience of one, a minority of one, protesting, trying to protect my rights, to protect my pride. I finally hit on a compromise—that's how I finished. I admitted my limitations, it was an invention and an excuse but also the truth, even though not my truth, the truth I could believe in. In fact, one never finishes; never reaches his goal; never becomes perfect. The work of analysis has to go on without the analysis, without the analyst, the patient would have to become the analyst. It had become too painful to continue. And not to leave any misunderstanding about it, not to make my analyst suspect that his work was not effective, I had to explain that the pain was not the pain that comes with the work of analysis, the pain of self-searching

and of self-confrontation, I had to explain that the pain was material, the money that seemed to go down the drain every month, and the hurt pride, the idea that others who had started with me or after me had finished already. And that tells also about the inadequacy of my analysis, when matters of money and pride had still such an importance for me, were more important than my own salvation, my own analysis. But, of course, in both these factors, the financial and the narcissistic, there was implicit the concern about my wife and my very ambivalent feelings about her very ambivalent feelings about my analysis and, as I always suspect, especially when she is angry, about me and my worth. That's another thing, a propos, that analysis didn't help me much with: to love her when she is angry. I can't exactly say that I hate her then, but certainly don't love her when she is angry, even though I've learned to remember that she will soon be out of her anger and loving again. But this I could have probably learned even without analysis. So I terminated honorably—honestly, not just sincerely.

And now that I've started writing about my analysis, I could write a whole book about it. And perhaps I should. But for whom? For my analyst who is no longer behind me? For that special audience that I've always imagined when I keep a diary, or for myself of the future? For myself of right now, perhaps. As it is, I never, I rarely made any use of these diaries, other than this: to hear myself free associate.

When was the last time I kept a diary? During my worst hypochondriacal days—just before I started my analysis seven years ago (or was it eight)? I discontinued because I went into analysis. Perhaps I should not have. Perhaps I could have written an interesting book about it, like Wortis (1954) did with his analysis. Mine was also a fragment of an analysis, though much longer. And my analyst was not Freud.

Ten years ago:

December 25, 1980. I don't know if there is any sense in keeping this diary, especially when it becomes as painful as when I write about things I would rather not think about. It helps in moments of anxiety or conflicting alternatives, but to write about depressing things is another story. And as it is highly unlikely that I will ever use these notes for any literary writing, it makes no sense to just report sentiments or happenings. Perhaps I feel guilty about my unexpected reaction to Beata's presence at our farewell party last evening, which seems stupid at this point, stupid and inappropriate as if I were still an adolescent. I am feeling that only Greece can solve this late middle-age crisis, one way or another.

Twenty years ago I was afraid I was going to die soon from some mysterious illness like leukemia or Hodgkin's. Now again it's this vague feeling that my time is running out, even though I feel in good health, except for some mildly annoying prostate trouble. But I don't trust my good luck. And I say, like I said then, let's go back to Greece, to the land

of my childhood, old age and death won't bother me there. I am sure it's an illusion.

Six years ago:

February 15, 1983. Waiting for the bus to Patras, one more escape (but never escapade) from the dreariness of family existence—until I reach 67 and retirement and say: one less escapade to Patras. To be 60 is in itself depressing. But what is really depressing is the sense of declining creativity—not a new experience in my life, but more realistic now. And yet I look around and I am still attracted by the same thing: young pretty women who were never more than attractive images to touch only in my dreams.

The thought of returning to the States keeps returning with increasing attraction, even though there is no particular stress here, economically, professionally or otherwise, just to get away from a low grade depression that involves my wife and her constant reminder of her distaste for Greek reality, a distaste that I more or less share. But the real problem is the one I was facing back in Topeka, the awareness of growing old in terms of my remaining time to do things while still feeling young and the daydream of having another love affair or, at least, writing a book about it. The idea still haunts me, a daydream that has survived since childhood and adolescence—it's amazing how I feel the same as then in all respects, including my shyness, the expectation that the girl should take the initiative, and the fear of rejection if I made the first move, now on the grounds of old age. My mind goes to Peggy, the pretty medical student who is interested in psychiatry, when she was talking to me at the general assembly the other evening I felt that familiar weakness inside, self-conscious but also tenderly assertive, an urge to touch her hand, the soft, rosy skin of her hand. And knowing that she is going steady with a very attractive young man in her class did not quite discourage me. In fact, as with Beata once in Topeka, the idea had a certain appeal. Peggy wants to have a residency when we open our clinic. Perhaps it would be a way out. I am sick of seeing analytic patients, of teaching, of supervising therapy cases and dissertations, of finding no time for myself. And I need to write my novel, besides catching up with all my other writing projects—a psychiatric textbook, editing my alcoholism articles for a monograph. I need to liberate myself from the falsities of my life, mainly in order to spare time, even if I cannot have what I dreamed for a whole life. It's curious how little impact the last forty years have had on me. It's always my childhood and adolescence that come up in my mind, vivid like yesterday, as if the rest of my life were a transitional period to something that has never materialized, to a future fulfillment that is now crowded into a handful of years of diminishing strength and youthfulness. And yet, it's amazing how free

> I am from any somatic symptoms or concerns, all those real or imaginary symptoms that plagued my youth and adult life are gone, nothing bothers me except for the specter of a shrinking time perspective, the depressing awareness of my age.

As Bertrand Russell (1929) said, memory is the key to the concept of time. Without the ability to remember there would be no concept of past or future, our thinking and consciousness would be confined into a slow or fast-moving present, a perpetual present, a sense of presentness governed by our conscious or unconscious wishes. People who suffer from amnesia, whether old or young, neither worry about nor get any pleasure from their past experiences or what may be stored for them in the future. For the future is a kind of reversal of the past, transferring one's past experiences into a time perspective that is based on the ability to anticipate—the ability to fantasize ourselves into the domain of possibility, carrying along what we have experienced or learned in what has already happened, in the domain of the past. Into the presentness of the amnesic experience there should be neither sorrow nor anxiety, for such emotions are conditioned by the sense of time, by the awareness of the past and the future, respectively. There should be only blissful calmness, apathetic or nervous boredom and anger, feelings grounded on the present, with no reference to future or past. If an amnesic person behaves in a depressed or anxious way, as most elderly people who suffer from Alzheimer's disease do, it is only because they are not completely amnesic yet.

My mother had Alzheimer's. A little before she died, a few months ago, she had become an invalid, reduced to a nearly stuporous condition. It was painful to visit with her, for not only did she look incredibly old and, I dare say, ugly, but she could no longer recognize anyone, so far as I could tell. My sister, who used to visit with her more often and was more involved with her nursing care, thought otherwise; she was sure our mother could understand and feel much more than she did show. One day, shortly before she passed away, I mustered enough courage and went to see her. She was lying there, in her bed, with eyes closed, motionless, when my sister said: "Mother, your little Peter is here." And then, without opening her eyes, she smiled, and her smile lighted up her face in an ecstatic way, just for a few seconds. She said nothing, she did not move, she just smiled. She was young again. I knew I had seen this smile before, but I could

not tell when. It was probably, I surmised, in my early childhood, when I was a baby. Then I recalled that I had seen the same smile once before. It was in the face of a woman I was in love with, not my mother that time.

As I grow older, I think more of the idea of death, mine mostly rather than that of my friends or relatives of my age; which is narcissistic, I know, except that I have the feeling that the others will survive my death. I don't want to die. Not to want to die, though, is not the same as being afraid to die. I am not afraid to die. No longer.

In fact, I have the feeling that I have started dying. As I am more aware of aging, I have the feeling that part of me has somehow died. For example: I rarely have erotic dreams any longer. Yet, I am still daydreaming about falling in love. I haven't written my novel yet. I decided to wait until I write a psychiatric textbook first—in Greek, of course. I could have started writing my novel, instead. But I need to wait some more. It gives me something to hope. If I write it, something more of me will have died. I am afraid I can say the same about the wish to fall in love once more in my life. But it would be worse if the wish died before me.

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18

The Gradual Transition to a Full and Active Retirement

Haskell F. Norman, M.D.

At the San Francisco Psychoanalytic Institute where I was a training analyst for almost thirty years, there were occasional discussions about mandatory retirement for training analysts. The issue first surfaced about twenty-five years ago, at a time when many of our then senior colleagues were already close to or past the retirement age under discussion: 65 or 68. In order to avoid offending these seniors and also to obtain a consensus, we agreed to grandfather all those present and have the policy apply only to newcomers. The subject did not come up again until a few years ago when one of the newcomers reached the retirement age of 68. It was then agreed to postpone the retirement age to 70. After the age of 70 training analysts would not begin any new training analyses. I understand that a few years ago an attempt was made to revoke the grandfather provision, without success.

The implication of these discussions and actions was that aging had a negative impact on one's ability to conduct effective training analyses. At no time do I recall any discussions about retirement from the private practice of psychoanalysis in general.

As I enter my seventy-eighth year, I have just completely retired from the practice of psychoanalysis and psychiatry. Since my late sixties, I had been gradually reducing my patient load. I had been considering the prospect of retirement intermittently for years, but it always seemed more propitious to postpone these thoughts.

When I did consider retirement there always seemed to be two important obstacles. First, how would I be able to give up the profession which was the major intellectual interest in my life? The second was economic.

My first concern was commonplace in our practice. Most of us have seen analysts who were depressed either at the prospect of or after retirement. Their self-esteem was linked almost exclusively to their work. Often the therapy was to encourage them to direct their interests either to new vocations or avocations. Clearly, in order to have a happy retirement I would have had to develop satisfying and consuming interests outside the profession itself.

My economic concern was a more practical one. Most psychoanalysts are self-employed and have to provide for their own retirement. I would have to begin setting aside funds for retirement many years in advance. Successful investments have made it possible for us to continue our comfortable lifestyle after I phased out my professional work.

A few experiences through the years contributed to my decision to make plans for retirement. The first occurred many years ago when a patient was referred to me whose analyst, Dr. A, had died only a few days before. That the analyst's death was upsetting to the patient was not surprising. However, it developed that the analyst had been seriously ill for some time and that his death was not altogether unexpected. The patient was a young married professional whose principal complaint had been sexual inhibition. He had been in therapy for a number of years. Initially, he was treated by psychoanalysis. After a few years, the patient was told that he was not analyzable and that he needed a more directive type of therapy. This took the form of daily lectures on how to be a man. Apparently, the idea was that the patient had a "weak father" and needed a strong father with whom to identify. He was to become a man like his analyst. The latter had been an avid horseman so he instructed the patient to take up riding. He did. Another lesson was on the subject of the treatment of women. When the patient related his wife's continued complaints about his lack of sexual interest, the analyst advised him to punish her by ignoring her, which he did for a year. These lessons were related as examples of the "brilliance" of this new father whom he missed. My diagnosis was that of an obsessive-compulsive with strong masochistic features. I soon concluded that the analyst's judgment had become impaired, for as he grew older, he became progressively incapacitated physically

due to illness. He apparently compensated for his weakness by becoming grandiose. The more he lectured the patient, the more the patient protected himself from the recognition of the therapist's declining health and judgment by becoming submissive and admiring. The treatment continued even after the analyst became incontinent. I found the story surprising, if not shocking. It seemed so sadly obvious that the therapist had been using the patient for his own needs. It was not possible to ascertain how much of it was economic. At any rate, it was an extreme example of how pathology of the analyst affected a patient and wasted a few years of his life. Even though our later analysis was successful, the memories of the case remained for me an object lesson about the problems of the aging psychoanalyst.

A second lesson came sometime later. A student complained to the dean of our school that her analyst, Dr. B, was becoming very forgetful. On investigation, the analyst admitted that this had become a problem for him and agreed to the suggestion that he discontinue treatment. It later became known that this older colleague had developed Alzheimer's disease for which he was eventually committed to an institution where he died.

Not too long ago, one of my closest colleagues, Dr. C, and a most respected teacher still practicing in his eighties, developed a malignancy. The disease and the chemotherapy caused a rapid mental decline. Nonetheless, he insisted on maintaining contact with his patients if only by phone. There was no telling him that it was unwise. He clung to his patients as he clung to his life.

When I was close to 70, I had a heart attack. It happened when I was attending a scientific meeting at a considerable distance from home. My symptoms were intense epigastric discomfort which was unrelieved by antacids. Thanks to the help of some doctors at the meeting I was in a hospital emergency room within an hour and soon transferred to a coronary care unit. The seriousness of the situation was no mystery to me but was even more evident when my wife, daughter, and son-in-law arrived the next day. Fortunately, with treatment, the acute symptoms subsided within a few days, and I was out of the hospital and home in about three weeks. My daughter and son-in-law, both internists, made arrangements with a local cardiologist for my care on my return. As I was now a cardiac patient, it was a relief to have my wife and daughter accompany me home. My new physician, after receiving my history, prescribed medication, mild exercise, moderate diet, and no work for several weeks.

This was not the first time I had been ill and close to death. In my thirties I had bulbar polio from which I recovered, but not without residuals. Then, I was still a young man. This fact as well as my optimistic personality enabled me to deal rather effectively with the trauma and its consequences. The idea of being "young" seemed to provide the magical assurance that children usually have when they become aware of death. Wasn't the disease called "infantile paralysis" anyway?

During the weeks of convalescence from the heart attack, there was ample time for introspection and self-analysis. I flashed back to a lecture in medical school on coronary disease. The professor had quoted an authority, "If you have a coronary as a young man and take good care of yourself, you will live to a ripe old age." This was later borne out by the father of a friend who had a coronary in his fifties. He had been a hard working obstetrician and immediately stopped his practice, retired, and moved to Florida where he lived to be over 90 years old. I tried to track down the source of the professor's quotation without success. Thinking that it possibly came from the old English surgeon John Hunter, I examined an available biography. Here I found, instead, something else that was worth considering. Hunter had recognized that anger exposed him to severe attacks of angina. He was quoted as saying, "My life is at the mercy of any rogue who chooses to provoke me" (Kobler, 1960, p. 209). My self-analysis had suggested the possibility that suppressed anger might have triggered my condition. I decided to avoid situations that might be provocative.

My wife urged me to retire at once. My son seemed unhappy at the prospect of my retirement. My daughter and her husband remained neutral. The cardiologist, perhaps respecting the fact that I was a psychoanalyst, left the decision to me. None of the doctors ventured a statement about my prognosis nor did I ask.

About eight years earlier, I had developed bilateral cataracts. At that time, intraocular lens implants were frowned upon by the ophthalmologists I contacted as potentially dangerous to the point of threatening blindness. As I was somewhat aware of what seemed to me more hopeful prospects from the medical literature, I decided to reject the traditional surgery and temporize. I became progressively blind and had to limit my activities such as driving my automobile. I do not think the problem limited my professional work beyond the

fact that I ceased accepting patients who would require hospitalization. Eventually, I contacted an expert ophthalmologist in another city who had an established record of success with intraocular lens implants and had the operation. The result was miraculous. Not only was I able to resume driving, but also I could read without glasses. I felt rejuvenated with 20/20 vision.

My medical prospects were different with the heart attack. There was no possibility of repair to my damaged heart. I remembered an old friend who, having had a coronary, would humorously respond when people commented on how well he looked: "The problem is not in my face."

To the obvious relief of my patients, I decided to return to my practice. Sometime later, I would here a guilty confession from my patients of the hope that I would live long enough to finish their analyses. Having no assurance that I would be alive for the next five or ten years, I decided that it would be unfair to start new analyses, training or otherwise. To encourage a patient to begin psychoanalysis with you carried with it the implicit promise to continue the treatment to termination. However, I did continue with patients already in analysis, and I am pleased that I was able to terminate all their treatments successfully. I finished with my last psychoanalytic patient about three years ago. During these last years, I found it necessary to pace myself carefully, as I would become quite drowsy at times, especially when I reclined behind the couch. To insure against falling asleep, I would schedule appointments so that I could nap betwixt and between. This drowsiness is attributable to both my medical condition and the medication I was taking. First, I cut back on the number of hours I practiced. After I stopped doing psychoanalysis, I reduced my workload from four to two days per week. During the last year, I worked only a few hours each day. I saw a few patients for psychotherapy. Occasionally, I saw a former patient for a few hours. I accepted new patients only for consultation. I also supervised the analyses of a few students in the Institute and a few graduate analysts.

What am I retiring to? During the years of my more active professional life, I developed a few significant avocations to which I could give only limited time and attention. About forty years ago I became a bibliophile. It began when I attempted to collect some of the psychoanalytic books and journals which were quite scarce in the United States shortly after World War II. I then progressed to collecting first editions of Freud's books and papers. Later, I became interested in

Freud's precursors: Charcot, Liebault, Bernheim and his colleagues Adler, Jung, Bleuler, Abraham, Rank, Ferenczi, and Jones, adding original editions of these authors to my library. Through the years, I expanded my interests to include the important ideas in the history of psychiatry, medicine, and science. Now my library includes original editions of important books beginning with the fifteenth century. Initially, my collecting was done entirely by correspondence. I would obtain booksellers' catalogues and reserve the last hours of the evening to peruse them and place my orders. Later when I attended professional meetings, I visited bookshops in New York, London, and Paris. This hobby brought me in contact with a new social milieu of booksellers, bibliophiles, librarians, and historians. I belong to several book clubs and occasionally participate in their meetings. One of the great satisfactions that this avocation coincidentally brought me was the fact that my only son, Jeremy Norman, went into the rare book trade, later established his own business, and now is one of the leading dealers in historical medical and scientific books in the world. He has taken a personal interest in my collection, and we spend a fair amount of time discussing it. Nine years ago, he engaged a librarian to catalogue my books. In 1991, the catalogue of the *Haskell F. Norman Library of Science and Medicine* was published by him in two volumes. It has become as anticipated a valuable reference work for professionals and amateurs who share my interest.

In my library there are two important classics pertinent to the topic of aging. The first is *M. T. Cicero's CATO MAJOR or his DISCOURSE of OLD-AGE with Explanatory NOTES, Printed and Sold by B. FRANKLIN, PHILADELPHIA, MDCCXLIV*. The book was written by Cicero in 44 B.C. when he was 63 years old, a year before his death, and is presented as a dialogue between the elder Cato, then 84, and two younger men in their thirties in which Cato presents some of the positive aspects of aging. I am under the impression that the original Latin edition, *De Senectute*, Cologne 1467 is the first printed book devoted solely to aging. An English translation appeared as early as 1481. We may assume that it was the author's attempt to deal with his own aging. Our copy is significant in that it is the first publication in America of a translation of a classic text and is the first book published in America devoted exclusively to this topic. We are told that the translation was done by the American scientist John Logan, then 60 years old, for a somewhat older friend who was less familiar with the Latin language. Benjamin Franklin wrote an Introduction in which

he stated that he had printed it "in a large and fair character, that those who begin to think on the Subject of OLD-AGE (which seldom happens till their sight is somewhat impaired by its approaches) may not, Reading by the Pain small letters give the Eyes, feel the Pleasure of the Mind in the least allayed" (Cicero, 44 B.C., p. v). The book is generally regarded as the finest example of printing to come off Franklin's press. It is also a typical example of Franklin's wisdom and humor. Whether or not he needed reading glasses at this time is something I have yet to verify. However, it is known that he was the inventor of bifocals.

There's a lot in Cicero's book which has merit today. For example:

> We must prepare ourselves, my Friends, against Old Age; and as it is advancing, endeavour by our Diligence to mitigate and correct the natural Infirmities that attend it: We must use proper Preservatives, as we do against Diseases; great Care must, in the first Place, be taken of our Health; all bodily Exercise must be moderate, and especially our Diet; which ought to be of such a kind, and in such Proportion as may be refresh and strengthen Nature, without oppressing it. Nor must our Care be confined to our Bodies only; for the Mind requires much more, which without it will not only decay, but our Understanding will as certainly die away in Old Age, as a Lamp not duly supplied with Oil. The Body, we know, when overlaboured, becomes heavy, and, as it were, jaded; but 'tis Exercise alone that supports the Spirits, and keeps the Mind in Vigour. Hence it is, that you see Old Men disadvantageously represented by *Caecilius*, and other Comic Poets on the Stage, when the Characters of weak and credulous, or dissolute Old Fellows, are exposed to Contempt and Ridicule: But these are the Vices only of such as, when grey with Years, abandon themselves to Idleness and Extravagance, and not of Old Age itself. For as Wantonness and Loose Desires are more peculiar to Youth than to the Aged; and yet not to all Youth, but to such only as are by Nature viciously inclined, or have been loosely educated; So that silly Dotishness, that is imputed to Old Age, will be found only in Persons of weak and abject Spirits [Cicero, 44 B.C., pp. 75–76].

Dr. George Pollock recently stated: "In this work Cicero anticipates much later gerontological research" (Pollock, 1987, p. 3).

I was in my mid-forties when I discovered that I needed reading glasses. I might have been more sensitive to this change were it not for the fact that I was surrounded by the above-mentioned senior colleagues who treated me as a junior. I had just been appointed training analyst and was usually spoken of as one of the "younger

ones." The cataracts which I later developed made a deeper impression on me than my middle-aged presbyopia.

The second book is Luigi Cornaro, *Trattato de la Vita Sobria*, Padua, 1558. The author, a Venetian nobleman, lived to the age of 98 and credited his longevity to his practice of moderation in all things. The title translates as "A Treatise on the Sober Life." He was in poor health in his thirties due to excessive indulgence in eating, drinking, and passions. To cure himself he restricted his food intake to 12 ounces of solid food (bread, meat, and eggs) and 14 ounces of new wine. The medical historian Sigerist analyzed this diet and estimated that it added up to 920 calories (1956). He noted that Cornaro was unclear about whether this was his intake for one meal or for each of two (in which case it would still add up to about 1800 calories per day). Cornaro also advised avoiding excesses of temperature, fatigue, and excitement. This book was written when he was 83. He followed it with additional treatises at 86, 91, and 95. These writings were translated into several languages. It has been estimated that more than one hundred editions were published. Cornaro has been called "The Apostle of Senescence" (Freeman, 1979, pp. 36–37). His book has been ranked with that of Cicero in the geriatric literature.

A book which I do not possess but which is important as the first book on geriatrics is that of the Veronese physician Gabriele Zerbi, *Gerontocomia*, Rome, Eucharius Silber, alias Franck, 27 November 1489. My son Jeremy Norman had a copy in his catalogue 18, 1987, item 665 from which I quote:

> The book is a guide to the proper hygiene, physical and mental, as well as particular to the diet of the aged. . . . The book represents a long step forward in the enlightened treatment of the handicapped. . . . A curious feature of the Gerontocomia is its complete neglect of women among the aged. Nonetheless . . . the Gerontocomia is the most complete and satisfactory treatise on geriatrics to reach us from either the Middle Ages or the renaissance and as such remains the classic Latin work on the subject, still unfortunately untranslated into any modern tongue. Zerbi remains the founder of the science of geriatrics [Lind, 1975, *Pre-Vesalian Anatomy*, p. 151, also pp. 141–146 with biography of Zerbi, who produced the last and best medieval anatomy, & giving further details of contents of his geriatrics book; Luth, 1965, *Geschichte der Geriatrie*, p. 125].

An English translation of this book has recently been published.

In 1985 when the International Association of Bibliophiles held their biennial congress in California, I provided an exhibit from my

collection. With the assistance of my son and his staff we selected 123 books and manuscripts which were also described in a catalogue prepared for the occasion (J. Norman, 1985). This activity created so much favorable comment that I was invited to address this group as well as members of the Danish Association of Bibliophiles and the Danish Osler Society at the next congress in Copenhagen in 1987.

The talk, as presented, was entitled "Freud, Osler, and the Norman Collection." Here, I traced the influence of Freud and Sir William Osler on my development as a bibliophile.

While I was preparing this talk, I made the discovery that there had been communications between Freud and Osler, first, on the subject of infantile cerebral palsy (about which both published books before the turn of the century) and again, years later, about a patient Osler referred to Freud for treatment. This information stimulated me to write a paper on "Osler on Freud and Psychoanalysis" (Norman, 1989). A portion of this paper was read for me by Professor Garfield Tourney at the panel on "Sir William Osler and Psychiatry" at the meeting of the American Psychiatric Association in Montreal in May 1988. I later presented it to the Bay Area History of Medicine Club, San Francisco, as well as to the East Bay History of Medicine Club, Oakland, in February 1990, and most recently it was presented in May 1992 at the American Osler Society, San Diego.

In 1991, Stanford University in preparation for their exhibition of Freud's art collection invited me to exhibit my collection of first editions of Freud's books simultaneously. A handsome catalogue was printed to which I contributed a number of essays. The exhibition of my Freud collection was later on display in New York at the Grolier Club, the premier organization of bibliophiles in America. Now I am organizing for the Grolier Club an exhibition of *100 Books Famous in Medicine* to be held in the spring of 1994. This also entails the editing of a catalogue with essays and photographs of each of the selections, the essays to be prepared by a number of distinguished colleagues.

Recently, my wife and I celebrated our fifty-fourth wedding anniversary. Fortunately for both of us my wife has been generally in good health and has been a support during my various illnesses. My wife is a talented musician, artist, semiprofessional writer, and photographer. Her interests have had a strong influence on the second of my important avocations. Also she has not shared my bibliophilic interests in science and medicine, I have shared hers, especially in the library of cuisine which she has collected. Many years ago, long

before it was fashionable, before Julia Child, she became proficient in French cuisine and studied with the only French cooking teacher in our area. Later she followed this up with courses at the Cordon Bleu and La Varenne in Paris as well as with many chefs in America. She wrote and published in 1985 with Rene Verdon, the chef at the White House during the Kennedy administration, a book entitled *The Enlightened Cuisine*. The fact that my wife became a talented gourmet cook also added a new dimension to our social life in that we entertained in our home persons who shared this interest. As my assignment during these gourmet dinners was that of sommelier, I decided to make a study of wine. This eventually brought me in contact with others who enjoyed gastronomy. First, there were wine tastings and wine dinners. Then I started a small wine and food society which attracted so many potential participants that I started a second small group in the following year.

About 1975 I started the Marin County Chapter of the International Wine and Food Society which today has about six hundred members. Geographically, our membership spans many states as well as France, Canada, and Australia. These activities represent two great advantages to living in the San Francisco area: one, this is the birthplace of California Cuisine which has had a revolutionary influence on American taste, attracting a flow of talented professional and amateur food enthusiasts; two, the proximity to the burgeoning California wine country provides us with exciting new wines almost daily and an increasing traffic of oenophiles from around the world. We have been honored by some of the world's most distinguished connoisseurs, wine makers, hoteliers, and restaurateurs. In 1987, the Society of Bacchus America honored me with their lifetime achievement award which subsequently they have also bestowed upon wine celebrities, Michael Broadbent, Robert Mondavi, Andre Tchelistcheff, and Harry Waugh, and culinary luminaries, Julia Child, Belle Rhodes, and Jacques Pepin. A few years ago our members surprised me by voting to change the name to the Haskell Norman Wine and Food Society.

It is especially gratifying to have as associates several generations, including many young enough to be our children and grandchildren. In this respect I am living out Cicero's advice:

> Thus Old Age is ever honourable, where it takes Care to support its proper Rights, and gives them not weakly away, but asserts them to the last. For, as we commend such Youths, as show something of the Solidity

> of Age; so we do the same by the Aged, who express the Liveliness of Youth: And whoever pursues this Method, tho' he may become old and decayed in Body, will never be so in Mind, nor be found so in his Understanding [Cicero, 44 B.C., pp. 77–78].

Or perhaps appropriately, "Some Wines sour with Age, while others grow better and richer" (Cicero, 44 B.C., p. 125).

I am often asked how I, a psychoanalyst, became so involved with wine and food. Whenever I need a brief answer, I usually respond: "Having devoted most of my life attempting to make unhappy people a little happier, it is a pleasure to participate with happy people." It is also true that as a result of these activities we made more friends after I was 60 than during the previous sixty years of my life.

During my professional career we have always lived in the country, and I rarely had time to enjoy the advantages that country life affords. My practice has always been in the city, and for all practical purposes I used to be home only on Sunday. I often recall the words of a gardener who took care of things for us: "I am far better off than you. You live in God's country, and I am the one to enjoy it." Now, I have the leisure to enjoy my garden.

Earlier, I mentioned my children, both of whom live close by. My daughter and son-in-law, both excellent physicians, are a great comfort for a cardiac patient to have as neighbors. In addition, we have mutual interests in medicine, wine, and food. I have already discussed some of the pleasures I share with my son.

Most older people whom I have known either as patients or colleagues, when thinking of death, would prefer to die in their sleep, a wish that is rarely granted. What is most feared is a lingering, painful, incapacitating illness. Faced with the latter prospect, one would like the option that Schur (1972) tells us Freud chose for himself—to have his life terminated by morphine.

Wisdom encourages us to live as best we can as we grow older, and discourages us from dwelling on the alternative. Henry Adams, the eminent Bostonian, listed among the disagreeable certainties age, senility, and death "against which one made what little resistance one could" (Adams, 1918, p. 344). The various regimens of diet, exercise, and activity proposed to help preserve one's physical and mental vitality in old age contribute to a transient sense of mastery as well as some possibility of denying the impact of the progression of aging.

Early in this discourse I said I was approaching retirement slowly. Despite my resolve it was not easy to close my office door permanently. The good fortune is that I was able to do it at my own pace.

It has been my conviction throughout my professional life that a psychoanalyst, in order to be objective, must not depend on his patients for economic or emotional support. This does not ignore the fact that we derive our income from our practice. It means that if we need any one patient for economic reasons, we are in trouble. The same holds for needing patients for narcissistic gratification or emotional support as seems to be the case with ailing physicians A, B, and C described earlier. In all three cases their progressively terminal illnesses impaired their judgment. I have no census as to what percentage of our profession like Freud (Schur, 1972, p. 279) prefer to die in harness or with their boots on. Obviously, I do not plan to. I could rationalize with my friends that I still have much to offer. However, I have noted that there is no dearth of younger people to fill the void left by my withdrawal. I decided to retire before old age impaired the quality of my work. I want to close my book with the thought of a job well done.

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